PEEHIP

Public Education Employees' Health Insurance Plan

Member Handbook

The Retirement Systems of Alabama

Public Education Employees' Health Insurance Plan (PEEHIP)

Office Location
201 South Union Street
Montgomery, AL 36104-0001
www.rsa-al.gov

Mailing Address
P. O. Box 302150
Montgomery, AL 36130-2150

Phone Numbers
334-517-7000
877-517-0020
Fax: 334-517-7001 or 877-517-0021

Student Verification
334-517-7000
877-517-0020

Flexible Spending Accounts
334-517-7000
877-517-0020

Wellness Program ***(Offered by PEEHIP & administered by the Alabama Department of Public Health)***
RSA Tower, Suite 900
P.O. Box 303170
Montgomery, AL 36130-3017
334-206-5300 or 800-252-1818
www.adph.org

Tobacco Cessation Quitline
800-QUIT-NOW
800-784-8669

Weight Watchers
334-206-5300
800-252-1818

Blue Cross and Blue Shield of Alabama

Administrator of Hospital/Medical, Flexible Spending Accounts, Supplemental, and CHIP Plans

450 Riverchase Parkway East
P.O. Box 995
Birmingham, AL 35298
www.bcbsal.org/peehip1/

Customer Service
800-327-3994

Preadmission Certification
800-354-7412

Flexible Spending Accounts
800-213-7930

Rapid Response to order ID cards, directories and claim forms
800-248-5123

Fraud Hot Line
800-824-4391

Express Scripts, Inc.

P.O. Box 66773
St. Louis, MO 63166-6773
www.express-scripts.com

Curascript Specialty Pharmacy
866-848-9870
www.curascript.com

Fax: 888-773-7386

Customer Service
(Available 24 hours/day)
866-243-2125

Prior Authorization for Step Therapy
800-347-5841

Fax: 800-357-9577

Pharmacy Help Desk *(Available 24 hours/day to assist pharmacists with PEEHIP questions)*
800-235-4357

VIVA Health Plan HMO

1222 14th Avenue South
Birmingham, AL 35205
205-558-7474
800-294-7780
www.vivahealth.com

Delta Dental Customer Service
(Dental provider for VIVA HMO Plan)
800-521-2651

Southland National Insurance Corporation

Administrator of Cancer, Dental, Indemnity, and Vision Optional Plans
1812 University Blvd.
P.O. Box 1250
Tuscaloosa, AL 35403
800-476-0677
www.southlandnationalpeehip.com

PEEHIP Member Handbook

Introduction

The Retirement Systems of Alabama (RSA) is pleased to provide you with the 2008-2009 Public Education Employees' Health Insurance Plan (PEEHIP) Member Handbook. This handbook is an important part of our commitment to provide our members with valuable information about their health care benefits. Please read this handbook thoroughly and keep it with your other benefit materials. Your member handbook is a very useful tool when you have questions about your PEEHIP benefits. It will help you make informed decisions about your future.

The information in this handbook is based on the Code of Alabama 1975, Title 16, Chapter 25A. This handbook is not intended as a substitute for the laws of Alabama governing PEEHIP nor will its interpretation prevail should a conflict arise between its contents and Chapter 25A. Furthermore, the laws summarized here are subject to change by the Alabama Legislature. Do not rely solely upon the information provided in this handbook to make any decision regarding your health care benefits, but contact PEEHIP directly with any questions you may have about your health care benefits.

Cover photos (from left to right): Pavilion Park, Montgomery; The Shoals, Muscle Shoals; The Battle House, a Renaissance Hotel, Mobile; RSA Helen Hunt Early Learning Center, Montgomery

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Summary of PEEHIP Policies

Open Enrollment Deadline Dates

The Open Enrollment period begins July 1 and ends August 31 for changes to be effective October 1. Each year, all PEEHIP eligible active and retired members are sent an Open Enrollment packet to their home address. All of the enrollment forms and information for new members to enroll or make insurance changes are included in this packet. Members have until September 10 to make Open Enrollment changes **online** through Member Online Services. The Member Online Services link can be found on the PEEHIP Web site at www.rsa-al.gov. All **paper** Open Enrollment forms and written requests submitted must be postmarked no later than August 31 for PEEHIP to accept the written request. No Open Enrollment changes can be made after these deadlines.

If members do not wish to make changes to their PEEHIP coverage, they do not need to complete the Open Enrollment application. They will remain enrolled in the same or existing plan(s), and the appropriate premium will continue to be deducted. **Exception:** Members who want to enroll or renew their Flexible Spending Accounts, Federal Poverty Level Premium Discount, or Children's Health Insurance Program must re-enroll each year. These three programs do not automatically renew each year without an application.

Insurance Premiums and Enrollments

Insurance premiums and enrollments are handled by PEEHIP, not by the employer. PEEHIP determines and manages the premium deductions; therefore, active and retired members are required to send all insurance changes to PEEHIP.

Prior to the payroll cutoff date, PEEHIP sends an electronic file to each employer authorizing the payroll deductions for each employer. The payroll deduction amount is based on the insurance plan(s) each member selects. If the payroll deduction is incorrect, members need to contact PEEHIP instead of their employer. It is imperative for PEEHIP to have your correct home mailing address so all members can receive important PEEHIP information.

Non-tobacco User Discount

All PEEHIP members enrolled in the PEEHIP Hospital Medical or HMO plan are charged a $23.00 per month PEEHIP premium increase. However, non-tobacco users can have the $23.00 surcharge removed from their monthly premium by certifying that they (and their spouse, if the spouse is covered as a dependent) have not used tobacco products within the last 12 months. Members must certify their tobacco status to PEEHIP to qualify for the $23.00 to be removed from their monthly premium.

If you have previously certified your tobacco status and your spouse's tobacco status (if you have family coverage), you do not need to re-certify every year. You are only required to complete a Health Insurance and Optional Status Change form if your or your spouse's tobacco status changes during the year. **New employees** who enroll in the hospital medical or HMO plan must certify their tobacco status (and their spouse's tobacco status if covered as a dependent) by completing the tobacco questions on the Health Insurance and Optional Enrollment Application. The tobacco surcharge only applies to the PEEHIP Hospital Medical Plan or HMO Plan and not the PEEHIP Optional Plans.

Retiree Sliding Scale Premium

Members who retired after September 30, 2005, are subject to a sliding scale premium, based on years of service. The premium for retiree coverage is broken down into the employer share (what PEEHIP pays) and the retiree share. Under the sliding scale, the retiree is still responsible for the retiree share; however, the employer share will increase or decrease based upon a retiree's years of service.

For members retiring with 25 years of service, PEEHIP pays 100% of the employer share of the premium. The member will only be responsible for the employee share of the premium. Each year less than 25, the PEEHIP share of the premium is reduced by 2% and the retiree share is increased

accordingly. For each year of service above 25, the employer (PEEHIP) share increases by 2% and the retiree share is reduced accordingly. PEEHIP members who retire on disability but are also eligible for service retirement are subject to the sliding scale for PEEHIP premiums.

All members who retired before October 1, 2005, are not affected by the Retiree Sliding Scale Premium. A chart illustrating the sliding scale premiums can be found on the RSA Web site at www.rsa-al.gov.

The retiree sliding scale premium will not apply to disability retirements for twelve (12) months from the member's date of retirement, provided the member submits to PEEHIP proof of application for Social Security Disability benefits. The exemption from the sliding scale premium can be extended beyond twelve (12) months from the member's date of retirement if the member qualifies for Social Security Disability benefits during the twelve (12) months following the member's date of retirement and proof of the Social Security Disability is provided to PEEHIP. For those qualifying, the premium adjustment will be made effective the first day of the second month following receipt of the Social Security notification by PEEHIP, provided it is received within twelve (12) months of the member's date of retirement.

Retiree Other Employer Group Health Insurance Coverage

Legislation requires certain members who retired after September 30, 2005, to take other employer health insurance. PEEHIP members who (1) retired after September 30, 2005, (2) become employed by another employer and (3) the other employer provides at least 50% of the cost of single health insurance coverage, and (4) are eligible to receive the other employer group health insurance coverage, must use the other employer's health benefit plan for primary coverage.

PEEHIP retirees must drop the PEEHIP coverage as their primary coverage and enroll in the new health plan through their new employer. The retiree may enroll in the PEEHIP Supplemental Plan within 30 days of eligibility for other group health insurance coverage. Failure by a retiree to enroll in the other employer's group health plan under the terms of the Act will result in the termination of coverage in PEEHIP and claims will be recalled back to the date the retiree was eligible for the other employer's group health plan.

IMPORTANT: Retired members who are ineligible for the PEEHIP coverage cannot be covered as a dependent on their spouse's PEEHIP coverage.

Supplemental Coverage Plan

PEEHIP members may opt to elect the PEEHIP Supplemental Plan as their Hospital Medical coverage in lieu of the PEEHIP Hospital Medical Plan. The PEEHIP Supplemental Plan will provide secondary benefits to the member's primary plan provided by another employer or TriCare coverage. Only active and non-Medicare retiree members and dependents are eligible for the PEEHIP Supplemental Plan. There is no premium required for this plan, and the plan covers most out-of-pocket expenses not covered by the primary plan.

The PEEHIP Supplemental Plan imposes the same exclusions and limitations that are in the PEEHIP primary Hospital Medical Plan. Additionally, the PEEHIP Supplemental Plan does not pick up services excluded by the other group plan. Blue Cross and Blue Shield of Alabama is the administrator for the PEEHIP Supplemental Plan. The PEEHIP Supplemental Plan cannot be used as a supplement to Medicare, the PEEHIP Hospital Medical Plan, or the State or Local Governmental Plans administered by the State Employees' Insurance Board (SEIB). In addition, active members who have TriCare or Champus as their primary coverage cannot enroll in the PEEHIP Supplemental Plan. Additional information on the Supplemental Plan can be found on page 17.

Federal Poverty Level Assistance Program (FPL)

PEEHIP provides premium assistance to qualifying members based on the Federal Poverty Level. PEEHIP members who have a combined family income of 200% or less of the Federal Poverty Level (FPL) may qualify for a reduced premium on their hospital medical or HMO premium.

To qualify for the FPL assistance, PEEHIP members must furnish acceptable proof of total income based on their most recently filed Federal Income Tax

Return along with copies of pertinent W-2's and 1099's. **The premium discount is effective for the plan year only. Re-certification is required annually during Open Enrollment.** The most recent Federal Poverty guidelines are listed on the back of the FPL AND CHIP APPLICATION which is in this handbook as well as on the PEEHIP Web site at www.rsa-al.gov.

Children's Health Insurance Program (CHIP)

PEEHIP offers a program to children of public education employees who qualify for the Federal Poverty Premium Discount. PEEHIP CHIP is a low copay program for children under the age of 19 who would normally qualify for the PEEHIP Hospital Medical Plan.

The PEEHIP member must be enrolled in the individual PEEHIP Hospital Medical Plan and must furnish acceptable proof of total income based on his or her latest Federal Income Tax Return along with copies of pertinent W-2's and 1099's. **Enrollment in PEEHIP CHIP is effective for the plan year only. Pre-certification and re-enrollment is required annually during Open Enrollment.** Additional information on CHIP can be found on page 18.

Medicare Part D

PEEHIP elected to continue providing prescription drug benefits to Medicare-eligible retirees and covered dependents even when these members are eligible for the new Medicare Part D program. However, if a Medicare-eligible member or dependent chooses to enroll in the Medicare Part D program, he or she will lose the PEEHIP prescription drug coverage.

Medicare-eligible members and dependents still need Medicare Part A and Part B but not Part D. Most Medicare-eligible members and dependents should not enroll in Medicare Part D if they are covered by the PEEHIP Medicare Plus program.

Public Education Employees' Flexible Spending Accounts (Flex)

PEEHIP manages and administers the Flexible Spending Accounts to all active employees. The Flexible Spending Accounts are available to **active** members of PEEHIP. Retired members are not eligible to participate in any of the Flexible Spending Accounts.

The PEEHIP Flexible Spending Accounts consist of the following three programs:

1. **Premium Conversion Plan (PCP)** requires all active members to pay PEEHIP premiums using pre-tax dollars. This plan is strictly a function of the payroll system in which the member no longer has to pay federal and state of Alabama income taxes on their health insurance premium.
2. **Dependent Care Flexible Spending Account** allows eligible active members the opportunity to pay dependent care expenses using pre-tax dollars.
3. **Health Care Flexible Spending Account** allows eligible active employees to set aside tax-free money in an account to pay themselves back for eligible health care expenses that were not covered by their insurance plan.

Open Enrollment for the Flex plans is July 1 through September 30, for an effective date of October 1. Members must complete and submit to PEEHIP prior to September 30 the online Flex Enrollment form accessible through the Member Online Services link at www.rsa-al.gov; or the Flex Enrollment form located in the back of this handbook. Blue Cross and Blue Shield of Alabama is the administrator for the Flex program. Additional information about the PEEHIP Flex accounts can be found on page 19 of this handbook.

New employees can enroll in the Flexible Spending Accounts within 30 days of employment.

Enrollment in the PEEHIP Flexible Spending Accounts is effective for the plan year only. Re-enrollment is required annually during Open Enrollment. These programs do not automatically renew each year.

Non-Duplication of Benefits

All PEEHIP members and covered dependents who use their PEEHIP Hospital Medical Plan as their secondary plan will still be required to pay any copays or deductibles imposed by PEEHIP. PEEHIP will cover the portion of the health plan deductibles and copays that exceed the PEEHIP copays.

Insurance Eligibility

Guidelines for Insurance Eligibility for Active Members

Full-time employees and permanent part-time employees are eligible for coverage with PEEHIP.

Full-time Employees

A full-time employee is any person employed on a full-time basis in any public institution of education within the state of Alabama. These institutions must provide instruction for any combination of grades K through 14 exclusively, under the auspices of the State Board of Education.

Permanent Part-time Employees

An eligible permanent part-time employee is not a substitute or a transient employee. A permanent part-time employee is eligible for PEEHIP if he or she agrees to payroll deduction for a pro rata portion of the premium cost for a full-time employee. The portion is based on the percentage of time the permanent part-time worker is employed.

Ineligible Employees

The following employees are not eligible to participate in PEEHIP:

- A seasonal, transient, intermittent or adjunct employee who is hired on an occasional or as needed basis.
- An adjunct instructor who is hired on a quarter-to-quarter or semester-to-semester basis and/or only teaches when a given class is in demand.
- Board attorneys and local school board members if they are not permanent employees of the institution.
- Contracted employees who may be on the payroll but are not actively employed by the school system.
- Extended day workers hired on an hourly or as needed basis.

Family Coverage Eligibility

Members can enroll their eligible dependents under PEEHIP by: 1) enrolling online at www.rsa-al.gov; or 2) filing a Health Insurance and Optional Enrollment Application with PEEHIP.

An eligible dependent is defined as:

1. The employee's lawful spouse as defined by Alabama law;
2. Unmarried dependent child under the age of 19, only if the child is:
   a. The employee's biological son or daughter;
   b. The employee's legally adopted child (including any probationary period during which the child is required to live with the employee);
   c. The employee's stepchild[1] or foster child[1] fully dependent upon the employee for support and permanently residing in the employee's household in a normal parent-child relationship[2] with no foreseeable or expected termination.
   d. A child related to the employee by blood or marriage who is fully dependent upon the employee for support and permanently residing in the employee's household in a normal parent-child relationship[2].
3. The employee's:
   a. unmarried dependent child between the ages of 19 and 25,
   b. who has his legal residence with the employee,
   c. is wholly dependent upon the employee for maintenance and support, and
   d. is a registered full-time student at an accredited secondary or postsecondary school, college or university. All conditions [(a), (b), (c) and (d)] must be met for the child to be an eligible dependent.
4. Unmarried dependent child of any age incapable of self-sustaining employment because of a physical or mental handicap and is chiefly dependent on the employee for support. The handicap must have existed prior to the time the child attained age 19 or age 25 if the child was a full-time student. Also, the child had to be covered as a dependent on the employee's PEEHIP policy before reaching the limiting age. For example, approved incapacitated children can continue on any PEEHIP plans they are on at the time they age out, but they are not eligible to be covered on other PEEHIP plans once they reach the limiting age.

The employee must contact the PEEHIP office and request an INCAPACITATED DEPENDENT form. Proof of the child's condition and dependence must be submitted to PEEHIP within 45 days after the date the child would otherwise cease to be covered because of age. PEEHIP may require proof of the continuation of such condition and dependence. If the child is approved as an incapacitated child and allowed to stay on the PEEHIP Hospital Medical Plan, the child cannot change plans and be covered on other PEEHIP plans, such as an HMO or Optional Plan if he or she has already reached the limiting age (19 or 25).

Ineligible Dependents

- Once an "eligible" dependent has "married" or "aged out," that person is ineligible to participate in PEEHIP again as a dependent except subsequently as the spouse of an eligible member. The ineligible dependent must be removed from coverage the first of the month following the event.
- Ex-spouses are not eligible dependents even if a member continues to pay for family coverage. The ex-spouse must be deleted from coverage effective the first day of the month following the date of divorce.
- Stepchildren who do not live in the member's household.
- An employee who is eligible for PEEHIP as a subscriber cannot be covered as a dependent child on another PEEHIP policy.
- A student dependent and the student dependent's biological child cannot both be covered on the same policy.

[1] Appropriate documentation will be required by PEEHIP before child can be enrolled.

[2] The term normal parent-child relationship is defined as: A relationship where neither the child's natural mother nor natural father live in the employee's household (e.g. when a child's parents are both deceased, totally disabled or their whereabouts are unknown) and the employee and child's relationship has no foreseeable or expected termination.

Student Dependents

An eligible student dependent must meet **all** the following requirements:

1. Unmarried and between the ages of 19 and 25,
2. Have his or her legal residence with the employee,
3. Be wholly dependent upon the employee for maintenance and support, and
4. Be a registered student in regular full-time attendance at an accredited school.

A dependent must be a full-time student according to the school's status criteria.

Example:
If a dependent is only taking 10 hours and the school requires a student to take 12 hours to be full-time, the dependent would not be an eligible dependent for that term. If a dependent is attending more than one school during a given term and is not considered full-time at any one school, the student must be taking at least 12 hours total to be eligible for that term.

If a student is in full-time status for at least one full regular term (not a mini-term) during a school year, he or she can receive one term off during that same school year and still remain a dependent on subscriber's contract.

Example:
If a dependent is a full-time student for fall term and decides to take off the spring term, he or she is eligible to remain on subscriber's contract through the spring term. Beginning the summer term, the dependent would be required to be a full-time student again or the dependent loses eligibility as a student.

A dependent cannot take off or be part-time more than one term during a school year and remain on the subscriber's contract. A dependent must be full-time two out of three semesters or three out of four quarters during a school year.

If a student dependent does not attend school full-time for the fall term and wants to use that term as his or her "one free term" for the year but then does not attend school full-time for the next term, the dependent will be cancelled retroactive to September 1 and will not receive the free term.

When a dependent graduates from school, the dependent loses student dependent status at the end of the month in which he or she graduates regardless of the dependent's age. The dependent is not given a "free term" after graduation unless the dependent

has been accepted to an accredited postgraduate school and will begin classes within 90 days. Proof of acceptance is required by PEEHIP.

When a dependent is no longer eligible for coverage as a dependent, he or she may be eligible to continue health insurance coverage under COBRA. To elect coverage under COBRA, the member or dependent must notify PEEHIP within 60 days from the date the dependent is no longer eligible for coverage.

PEEHIP handles the student verification process for the PEEHIP Hospital Medical Plan and the Optional Plans. PEEHIP sends a student verification letter to the member a few months before the student dependent's birthday. The member must then use one of two methods to update the student dependent through PEEHIP: 1) online system method; or 2) phone method.

1. **Online System Update:** Members can easily and quickly update their student dependent online by clicking the Member Online Services link on the RSA's Web site at www.rsa-al.gov and following the on screen instructions. The member must timely update their student dependent online within the allowable 90 days from the date they receive the student verification letter.
2. **Phone Update:** Members can call the PEEHIP Student Verification phone line at 877-517-0020 and answer the recorded questions verbally. PEEHIP records the information and a staff member updates your account and transmits the student verification to the insurance carriers, who will update their records within 5-7 days.

If PEEHIP is given incorrect information, the member is responsible for all claims incurred by the student.

If a student dependent's status is not updated in a timely manner, the student dependent will be cancelled and PEEHIP will require written verification from the registrar's office before the student can be reinstated. If the student dependent's status changes during the year, the member is responsible for notifying PEEHIP.

War Duty Extension for Student Dependents

On March 5, 2007, the PEEHIP Board of Control approved insurance coverage beyond age 25 for student dependents who have been called to active duty and had to interrupt their college education. If the student dependent is over age 25 when returning from active duty military service or turns age 25 while completing college after returning from active duty, the student has the length of time equal to the time that was served in active duty to remain on the PEEHIP insurance coverage.

To be eligible for this extension, the student dependent must have been a dependent on the PEEHIP insurance policy at the time he or she was called to active duty and must return to school within 30 days of returning home from active duty.

Documents Necessary When Requesting the Student Extension:

1. A copy of the DD 214 Form from the United States Armed Forces
2. A copy of the college/university student verification form showing full-time student status
3. A PEEHIP status change form requesting to add the dependent student to the PEEHIP insurance coverage. The PEEHIP status change form can be downloaded from our Web site at www.rsa-al.gov.

Newly Acquired Dependents and Single Coverage

Marriage

A member enrolled in single coverage who marries and wishes to acquire family coverage must submit written notification to PEEHIP within 45 days of the date of marriage. The effective date of coverage may be the date of marriage or the first day of the following month. The 270-day waiting period on pre-existing conditions is waived if proof of previous coverage is received and approved by PEEHIP. Prior notification is not required.

If PEEHIP does not receive written notification within 45 days of the date of marriage, the policy cannot be changed to family and the new dependent cannot

be added until the Open Enrollment Period. This policy applies to active members only because the premiums for active members are pretaxed and IRS guidelines do not allow coverage changes outside of the 45 days from the qualifying event.

Newborn

An active member enrolled in single coverage who desires family coverage due to the birth of a child must submit written notification to PEEHIP within 45 days of the date of birth. The effective date of coverage may be the date of birth or the first day of the following month. A waiting period on pre-existing conditions is waived for the newborn child if the effective date is the date of birth. Prior notification is not required.

If PEEHIP does not receive written notification within 45 days of the date of birth, the policy cannot be changed to family and the new dependent cannot be added until the Open Enrollment period. This policy applies to active members only because the premiums for active members are pretaxed and IRS guidelines do not allow coverage changes outside of the 45 days from the qualifying event. If a newborn is not covered on the date of birth, claims for the newborn at the time of birth will not be paid.

When adding family coverage, a member can add all eligible dependents to the policy. However, the newly added dependents may be subject to the 270-day waiting period on pre-existing conditions unless proof of previous coverage is received and approved by PEEHIP. A member who is only enrolled in the four Optional Plans cannot enroll in the Hospital Medical Plan due to the birth of a child.

Newly Acquired Dependents and Family Coverage

If a member is enrolled in family coverage, the member may enroll a new dependent(s) by completing and mailing a Health Insurance and Optional Status Change form to PEEHIP within 45 days of acquiring the dependent(s). Prior notification is not required. Application for dependent coverage must be made by the employee and approved and processed by PEEHIP prior to the payment of any claims.

Stepchildren

To add stepchildren, the member must attach to the Health Insurance and Optional Enrollment Application documentation that the stepchild is residing in the household. Acceptable documentation would be school records, divorce papers, etc.

Other Dependent Children

When adding a dependent child other than the member's biological child or stepchild, the member must attach to the Health Insurance and Optional Enrollment Application documentation of custody or guardianship and provide information as to the relationship to the member. The dependent must be related to the employee by blood or marriage and must be fully dependent upon the employee for support and permanently residing in the employee's household in a normal parent-child relationship. In addition, PEEHIP requires appropriate documentation as to the whereabouts of the natural mother and father, such as custody or guardianship papers, notarized statement, etc. If custody is temporary, the dependent child must have resided in the member's household for at least one year before the dependent can be considered for coverage.

Dependents with Different Last Names

If a husband and wife have different last names, the member must mail a copy of the marriage certificate to PEEHIP after adding the new spouse to their coverage through the Member Online Services at www.rsa-al.gov; or must attach a copy of the marriage certificate to the Health Insurance and Optional Enrollment Application.

If biological children have different last names, the member must mail a copy of the birth certificates to PEEHIP after adding the children to their coverage through the Member Online Services at www.rsa-al.gov; or must attach a copy of the birth certificates to the Health Insurance and Optional Enrollment Application.

Enrollments cannot be processed without the appropriate documentation as explained above.

PEEHIP is not bound by a court order to insure dependents who do not meet PEEHIP guidelines.

Enrollment Issues

Open Enrollment

Current Employees

Waiting periods on pre-existing conditions will be waived for members/dependents enrolling in new coverages that are effective October 1.

New Employees

New employees may enroll on their date of employment, the first day of the month following employment, or October 1. The Health Insurance and Optional Enrollment Application must be completed within 30 days of the member's employment date. **If the form is not completed within 30 days, the employee is only allowed to enroll in single Hospital Medical coverage effective the date the form is completed.**

Waiting periods will apply on pre-existing conditions for all new coverages not effective on October 1, subject to the following conditions: new employees and dependents with effective dates of coverage on or after July 1 and before October 1 are given waivers on the waiting periods for pre-existing conditions.

Unless proof of previous coverage is received and approved by PEEHIP, employees with effective dates of coverage after October 1 and before July 1 are required to serve a 270-day waiting period on pre-existing conditions.

New employees employed during the Open Enrollment period cannot enroll in the Optional Plans on their date of employment and cancel the plans October 1 of that same year.

Transfers

Employees who transfer from one system to another system are considered current employees and must keep existing insurance coverage until the Open Enrollment period for changes to be effective October 1.

Enrollment Outside of Open Enrollment

Employees Hired After October 1

New employees hired after October 1 are required to serve a 270-day waiting period on pre-existing conditions unless proof of previous coverage is received and approved by PEEHIP. These employees may enroll only on their date of employment or the first day of the month following their date of employment.

New employees may add family coverage on their date of employment or within 60 days of employment. All enrollment forms must be completed within 30 days of member's date of employment or the employee is only eligible to enroll in single Hospital Medical coverage effective the date the form is completed.

New employees enrolled in Optional Plans outside of Open Enrollment are required to retain the coverage(s) for at least one year or until the next Open Enrollment period.

Employees who are employed less than full-time and are enrolled in only Optional Plans cannot add the Hospital Medical Plan outside of the Open Enrollment period if they become full-time.

Loss of Coverage

Involuntary Loss

Employees whose spouse or other dependent has an involuntary loss of Hospital Medical coverage are allowed to add family coverage to their existing Hospital Medical plan within 45 days of the loss of coverage. The member must send documentation from the employer in which coverage was lost stating the reason for the loss of coverage. In addition, the letter must provide the employment and termination date as well as the date the insurance coverage ended.

Members and/or dependent(s) are required to serve a 270-day waiting period on pre-existing conditions unless proof of previous coverage is received and approved by PEEHIP. If PEEHIP is not notified within 45 days, the member and/or the dependent(s) are required to wait and enroll October 1. Employees are only allowed to enroll in the **Hospital Medical Plan** when there has been a **loss of coverage**. The member cannot enroll in dental or vision coverage outside of Open Enrollment even if it was part of the plan in which they lost coverage.

Examples of involuntary loss situations:

- layoffs
- company discontinuing insurance coverage completely or changing insurance carriers (not just a change in benefits and premiums)
- spouse being fired
- divorce

Examples of loss of Hospital Medical coverage that are not considered involuntary:

- loss of coverage due to employment strike
- voluntary resignation or voluntary change in employment
- change in benefits or premiums with the insurance plan

Voluntary Loss

The Health Insurance Portability and Accountability Act (HIPAA) does allow special enrollment periods when a member or dependent loses other Hospital Medical insurance coverage in certain cases. The employee has 45 days to request special enrollment when there has been a voluntary loss of other coverage. HIPAA is explained in more detail in the HIPAA section of this Member Handbook.

An employee is eligible to drop any of the Optional Plans when he or she enrolls in Hospital Medical coverage due to a loss of previous coverage if he or she has had the Optional Plan(s) for at least one year.

When enrolling in Hospital Medical coverage, the member must complete a Health Insurance and Optional Enrollment Application and attach a letter stating the reason for the loss of coverage from the employer through which coverage was lost. In addition, the letter must provide the employment and termination date as well as the date the insurance coverage ended.

If loss of coverage is due to divorce, the member must indicate this on the form and give the exact date of divorce. If adding family coverage, the member must complete a Health Insurance and Optional Status Change form and provide the necessary information on dependents. The member is eligible to enroll in only the **Hospital Medical Plan** under HIPAA.

The member cannot enroll in dental or vision coverage outside of Open Enrollment even if it was a part of the plan in which they lost coverage.

Cancelling or Changing Coverage Outside of Open Enrollment - Active Member

On October 1, 2005, all active members began paying their premiums using pre-tax dollars. Therefore, active members must have an IRS qualifying event before they can be allowed to cancel their Hospital Medical Plan or change their coverage outside of the Open Enrollment period. Also, the request to cancel or change coverage must be within 45 days of the IRS qualifying event. Examples of IRS qualifying events are: 1) adoption of child; 2) birth of a child; 3) death of a spouse or dependent; 4) dependent over age 19 changing student status; 5) dependent loss of coverage; 6) divorce or annulment; 7) legal custody of child; 8) marriage; 9) marriage of dependent child; 10) termination of spouse employment; 11) commencement of spouse employment, or 12) Medicaid/Medicare entitlement. Appropriate documentation must be received and approved before the change can be made.

If all dependents on the policy are ineligible, the coverage will automatically change to an individual plan effective the first of the month following the cancellation of the last remaining dependent. When a policy is cancelled, the coverage remains in effect through the last day of the month. Policies cannot be cancelled in the middle of a month.

Changes Permissible During Open Enrollment

PEEHIP Hospital Medical, HMO Plan, Optional Plans, or PEEHIP Supplemental Plan

Single or family coverage enrollment:

- Add dependent coverage
- Add additional eligible dependents
- Transfer from one PEEHIP Hospital Medical Plan to another PEEHIP Hospital Medical Plan or an HMO Plan
- Transfer from PEEHIP Supplemental Plan to PEEHIP Hospital Medical Plan
- Apply for PEEHIP CHIP for eligible dependent children
- Apply for Federal Poverty Discount on hospital

medical premiums
- Enroll in Flexible Spending Accounts for active members.

Optional Plans (Cancer, Dental, Hospital Indemnity and Vision)

- The state allocation will pay in full for the four Optional Plans for a full-time active employee who is not enrolled in one of the Hospital Medical Plans.
- If an employee wants to apply the state allocation to the PEEHIP Hospital Medical Plan or the HMO Plan, he or she may purchase one or more Optional Plans. The cost is $38.00/ month for each plan.
- Optional Plans must be all "Single" or all "Family" plans.
- The Optional Plans must be retained for the entire insurance year, i.e., through September 30.
- New employees employed during the Open Enrollment period cannot enroll in the Optional Plans on their date of employment and cancel the plans October 1 of that same year.
- Members enrolled in family Optional Plan(s) cannot change to single Optional Plan(s) outside the Open Enrollment period unless all dependents become ineligible due to age, death or divorce.

Waiting Periods

Waiting periods on pre-existing conditions will be waived under the following conditions:

- New retiree subscribers from non-participating units who join immediately upon retirement and have Hospital Medical coverage from the non-participating unit
- Subscribers of new units joining PEEHIP
- Subscribers of an HMO Plan who elect to transfer to PEEHIP Hospital Medical or PEEHIP Supplemental Plan coverage effective October 1 or vice versa
- Any non-subscriber of PEEHIP who elects to enroll in one of the PEEHIP Hospital Medical Plans or the HMO Plan during the Open Enrollment period for an October 1 effective date

Plan Summaries and Benefits

PEEHIP Hospital Medical Coverage

(Coverage for Active Members and Non-Medicare-eligible Retirees)

Hospital Benefits *(Administered by Blue Cross and Blue Shield of Alabama)*

- **Inpatient Hospitalization:** Services are covered in full for 365 days without a dollar limit.
- **Deductible:** $100 for each admission. You are also responsible for the difference between private and semi-private accommodations and other non-medical items, such as TV, phone, etc.
- **Preadmission Certification (PAC):** All admissions will be subject to Preadmission Certification by completing a Blue Cross and Blue Shield of Alabama Preadmission Certification form. Emergency admissions must be certified by the first business day following the admission by calling 800-354-7412.
- **Inpatient Rehabilitation:** Coverage in a rehabilitation facility is limited to one admission per illness or accident; one per lifetime with a 60-day maximum. Precertification is required.
- **Outpatient Hospital Charges:** $75 facility copay for outpatient surgery and $25 facility copay for medical emergencies and hemodialysis. There is no copay required for accident related services rendered within 72 hours after the accident.

Major Medical Benefits *(Administered by Blue Cross and Blue Shield of Alabama)*

- **Deductible:** $100 deductible per person per calendar year; maximum of 3 deductibles per family per year.
- **Maximum:** $1,000,000 lifetime maximum for each covered member.
- **Coinsurance:** After you pay the $100 deductible, the plan pays 80% of the Usual Customary Rates (UCR) of covered expenses for the first $2,000 and 100% UCR thereafter.
- **Covered Services:** Physician services for medical and surgical care when you do not use a PMD physician; laboratory and X-rays, (outpatient MRI's must be precertified); ambulance service; blood and blood plasma; oxygen, casts, splints and dressings; prosthetic appliances and braces; podiatrist services; physical therapy; allergy testing and treatments; semi-private room and other hospital care after basic hospital benefits expire.

Preferred Medical Doctor (PMD)

- **$3 Copay Per Test:** Outpatient diagnostic lab and pathology (including pap smears).
- **$20 Copay Per Visit:** Doctor's office visits and consultations; one routine preventive visit each year for adults age 19 and over.

PPO Blue Card Benefits *(Out-of-state Providers)*

- The Blue Card PPO program offers "PMD-like" benefits when members access out-of-state providers if the physician or hospital is a participant in the local Blue Cross PPO program in that state. This program allows members to receive PMD benefits such as well baby care, routine physicals and routine mammograms when accessing out-of-state PPO providers.

Non-participating Hospitals and Outpatient Facilities

- Currently, there are no non-participating inpatient or outpatient facilities in Alabama. However, when choosing a hospital or outpatient facility located outside Alabama, you may want to consider checking with the facility first to determine if they are a Blue Cross and Blue Shield participating provider. With your health plan benefits, you have the freedom to choose your health care provider.
- To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your health plan. Your out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, out-of-pocket expenses are minimized.

Out-of-Country Coverage

- If you receive medical treatment outside of the United States and the services are medically necessary, PEEHIP is the primary payer under

the major medical benefits. All PEEHIP deductible and coinsurance amounts and contract limitations will apply. The claims must be stated in U.S. dollars and filed with Blue Cross and Blue Shield of Alabama.

Pharmacy Program *(Administered by Express Scripts)*

- **Participating Pharmacy:** When you choose a Participating Pharmacy you pay the following:
  - $5 for any covered generic prescription drug
  - $30 for any covered preferred brand drug (The preferred brand drug list can be found on the PEEHIP Web site at www.rsa-al.gov.)
  - $50 for any covered non-preferred brand drug
- Participating pharmacies file all claims for you. Most major pharmacy chains in-state and out-of-state participate with the PEEHIP Express Scripts prescription drug plan.
- Members and covered dependents must use Curascripts for all specialty medications.
- The PEEHIP prescription drug plan includes Step Therapy and prior authorization for certain medications.

Non-Participating Pharmacy

- There are no benefits if you use a non-participating pharmacy in Alabama.
- **Coverage outside Alabama:** You will file the claim and be reimbursed at the Participating Pharmacy rate less the appropriate copay.

Excluded Services

- Coverage is not provided for nursing home costs, vision and dental care (except accidental injuries), cosmetic surgery, hearing aids and experimental procedures.

Wellness Program

(Administered by the Alabama Department of Public Health)

Members and dependents covered by the PEEHIP Hospital Medical Plan, HMO or Optional Plans can receive free health screenings by the Public Health Department nurses at different sites during the year. The health screening tests include blood pressure, glucose, and an HDL/LDL cholesterol screening as well as osteoporosis screenings for high risk members.

The PEEHIP Wellness Program also includes a smoking cessation toll-free Quitline (800-784-8669) which is available 24 hours a day providing live counseling from 8:00 a.m. until 8:00 p.m., Monday through Friday. The Wellness Program also includes a Weight Watchers benefit for high risk members who have a body mass index of 25 or more. The member's cost is $85.00 for a 15 week-program with PEEHIP paying the remaining $85.00. Members must attend at least 12 out of the 15 sessions to receive full reimbursement by PEEHIP.

You can calculate your body mass index on any of the following Web sites: www.nhlbisupport.com/bmi/, www.caloriecontrol.org/bmi.html, or www.consumer.gov/weight_loss/bmi.htm. Additional information can be obtained on the Public Health Department Web site at www.adph.org/worksitewellness, or by calling 334-206-5300 or 800-252-1818 and asking for the Wellness Division.

PEEHIP Medicare Plus

(Coverage for Medicare-Eligible Retirees)

This plan is a supplement to hospital and medical benefits provided under Medicare Part A and Part B, and is available to Medicare-eligible retirees. This coverage is similar in nature to C-Plus and other Medicare supplemental insurance plans. It provides hospital and non-hospital benefits as outlined on the chart on the following page. This plan does not provide benefits for custodial care such as help in walking, eating, bathing and dressing. Members must have Medicare Part A and Part B, and Medicare must be your primary payer for claims. Most Medicare-eligible members and dependents should not enroll in the Medicare Part D program if they are enrolled in the PEEHIP Medicare Plus plan.

If a Medicare-eligible member or dependent chooses to enroll in a Medicare Part D plan, he or she will lose the PEEHIP prescription drug coverage.

PEEHIP Hospital Benefits *(Administered by Blue Cross and Blue Shield of Alabama)*

Benefit		
Inpatient Hospital Charges		
Medicare Pays	**PEEHIP Pays**	**YOU Pay**
All but the Part A deductible per admission. All but applicable coinsurance after 60 days.	All but $100 per admission. Applicable coinsurance after 60 days.	A $100 deductible and any personal charges (such as private room, telephone, TV, etc.).

PEEHIP Non-Hospital Benefits

Benefit		
Outpatient Hospital Charges		
Medicare Pays	**PEEHIP Pays**	**YOU Pay**
80% of Medicare's approved amount after the Medicare Part B deductible.	20% of Medicare's approved amount after the member meets Medicare Part B deductible and the $20 copay for physician visit.	The Part B deductible, a copay up to $20 for physician visits, any charges not covered by Medicare or PEEHIP, and charges above the Medicare allowable amount when using unassigned providers.

Pharmacy Program *(Administered by Express Scripts)*

- **Participating Pharmacy:** When using a Participating Pharmacy you pay the following:
  - $5 for any covered generic prescription drug
  - $30 for any covered preferred brand drug (The preferred brand drug list can be found on the PEEHIP Web site at www.rsa-al.gov.)
  - $50 for any covered non-preferred brand drug
- Participating pharmacies will file all claims for you. Most major pharmacy chains in-state and out-of-state participate with the PEEHIP Express Scripts prescription drug plan.
- Members and covered dependents must use Curascripts for all specialty medications.
- The PEEHIP prescription drug plan includes Step Therapy and prior authorization for certain medications.

Non-Participating Pharmacy

- There are no benefits if you use a non-participating pharmacy in Alabama.
- **Coverage outside Alabama:** You will file the claim and be reimbursed at the Participating Pharmacy rate less the appropriate copay.

Out-of-State Coverage

- When you receive medical treatment outside Alabama, Medicare of that state is responsible for the payment of the claim. When you receive the Explanation of Medicare Benefits statement from that state, you must send Blue Cross and Blue Shield of Alabama a copy of the statement attached to a completed claim form in order for Blue Cross and Blue Shield of Alabama to consider the charges for payment. Always list your contract number on the claim form.

Out-of-Country Coverage

- If you receive medical treatment outside the United States, Medicare may not make payment. In this situation, if the services are medically necessary, PEEHIP will pay primary under the major medical benefits. All PEEHIP deductible and coinsurance amounts and contract limitations will apply. The claims must be stated in U.S. dollars and filed with Blue Cross and Blue Shield of Alabama.

Non-participating Hospitals and Outpatient Facilities

- Currently, there are no non-participating inpatient or outpatient facilities in Alabama. However, when choosing a hospital or outpatient facility located outside Alabama, you may want to consider checking with the facility first to determine if they are a Blue Cross and Blue Shield participating provider. With your health plan benefits, you have the freedom to choose your health care provider.
- To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your

health plan. Your out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, out-of-pocket expenses are minimized.

Excluded Services

- Coverage is not provided for nursing home costs, charges in excess of Medicare allowed charges, vision and dental care (except accidental injuries), cosmetic surgery, hearing aids, and experimental procedures.

Step Therapy Program

The PEEHIP prescription drug program includes Step Therapy for certain medications. The Step Therapy program was implemented to keep PEEHIP sound and to keep premiums and copayments at a reasonable and affordable level. The Step Therapy program applies to "new" prescriptions that have not been purchased in over 130 days. A prescription is considered "new" if the member or covered dependent has not filed and processed the prescription claim with Express Scripts in over 130 days.

Step Therapy is a program especially for people who take prescription drugs regularly to treat ongoing medical conditions such as arthritis/pain, heartburn, or high blood pressure. It is designed to:

- provide safe and effective treatments for your good health
- make prescriptions more affordable
- enable PEEHIP to continue to provide affordable prescription coverage while controlling rising costs

Step Therapy is organized in a series of "steps" with *your doctor* approving your medication every step of the way. It is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts. Together with Express Scripts, Inc. (ESI), they review the most current research on thousands of drugs tested and approved by the U.S. Food and Drug Administration (FDA) for safety and effectiveness.

How does Step Therapy work?

First Step: Generic drugs are usually in the first step. These drugs are commonly prescribed, less expensive treatments that are safe and effective in treating many medical conditions. Your copayment is usually the lowest with a first-step drug. It will be necessary for you to use the first-step drugs before the plan will pay for second-step drugs.

Second Step: If your treatment path requires more medications, then the program moves you along to this step, which generally includes brand-name drugs. Brand-name drugs are usually more expensive than generics, so most have a higher copayment.

When a prescription for a second-step drug is processed at your pharmacy for the first time, your pharmacist will receive a message indicating the PEEHIP plan uses Step Therapy. If you would rather not pay full price for your prescription drug, your doctor needs to give you a prescription for a first-step drug. Only your doctor can change your current prescription to a first-step drug covered by your program.

To receive a first-step drug:

Ask your pharmacist to call your doctor and request a new prescription

or

Contact your doctor to get a new prescription.

With Step Therapy, more expensive, brand-name drugs are usually covered in a later step in the program if you have already tried the first-step drug. If your doctor decides you need a different drug for medical reasons before you have tried a first-step drug, then your doctor can call Express Scripts to request a "prior authorization." If the second-step drug is approved, you will pay a higher copayment than for a first-step drug. If the drug is not approved, you will need to pay the full price for the drug. You can appeal the decision through the appeals process outlined in this handbook.

If you have medical reasons that prevent you from trying a first-step drug, your physician can contact Express Scripts to request a prior authorization by calling 800-347-5841. For other questions about the Step Therapy program, contact Express Scripts Customer Service at 866-243-2125.

VIVA Health HMO Plan

Description of Plan

The VIVA Health HMO Plan is a Hospital Medical Plan option available to members living in the VIVA Health service areas. Guidelines for the VIVA Health HMO are:

- Members are not required to choose a Personal Care Physician (PCP) from the VIVA Health directory, but they must use participating physicians and specialists.
- Members are not required to obtain a referral from a primary care physician to use a participating specialist.
- If members need services from a specialist, members can choose a specialist from the directory and make an appointment.

Service Area

Coverage with VIVA Health Plan is available in the following areas:

Autauga	Clarke	Fayette	Montgomery
Baldwin	Cleburne	Greene	Perry
Bibb	Conecuh	Hale	St. Clair
Blount	Coosa	Jefferson	Shelby
Bullock	Cullman	Lawrence	Talladega
Butler	Dale	Madison	Tuscaloosa
Calhoun	Dallas	Marion	Walker
Cherokee	Dekalb	Mobile	Washington
Chilton	Elmore	Monroe	Winston

A summary of the VIVA benefits is listed in the Comparison of Benefits section of this handbook.

The VIVA HMO plan is not available to retired members who are Medicare eligible or to Medicare-eligible dependents.

Remember, this is only a summary of benefits. Members should refer to the appropriate benefit booklet for detailed information and limitations.

Optional Plans

(Cancer, Dental, Hospital Indemnity, Vision Care)

There are four Optional Plans offered through PEEHIP. A synopsis of these plans is provided on the following pages. More detailed information will be provided to those who enroll in the plan(s). Claims administration is provided through the Southland National Insurance Company. All Optional Plans must be retained for the entire insurance year, i.e. until September 30. New employees employed during the Open Enrollment period cannot enroll in the Optional Plans on their date of employment and cancel the plans October 1 of that same year.

If a member is enrolled in more than one of the Optional Plans, the contracts must be all family or all single plans. Members enrolled in family Optional Plans cannot change to single Optional Plans outside of the Open Enrollment period unless all dependent(s) become ineligible due to age, death or divorce.

Claim forms for the Optional Plans can be downloaded from the Southland National Web site at www.southlandnationalpeehip.com.

Cancer Plan

- This plan covers cancer disease only.
- Benefits are provided regardless of other insurance.
- Benefits are paid directly to the insured unless assigned.
- Coverage provides $250 per day for the first 90 consecutive days of hospital confinement, $500 per day thereafter.
- Actual surgical charges are paid up to the amounts in the surgical schedule.
- The lifetime maximum benefit for radiation and chemotherapy coverage is $10,000. This benefit covers actual charges for cobalt therapy, x-ray therapy, or chemotherapy injections (excluding diagnostic tests).
- Benefits are also provided for hospice care, anesthesia, blood and plasma, nursing services, attending physician, prosthetic devices, and ambulance trips.

Dental Plan

- This plan covers diagnostic and preventative services, as well as basic and major dental services.
- Diagnostic and preventative services are not subject to a deductible and are covered at 100% (based on the Usual Customary Rates (UCR) for Alabama). These services include: oral examinations, teeth cleaning, fluoride applications for insured children up to age 19, space maintainers, x-rays, and emergency office visits.

- Routine cleaning visits are limited to two times per plan year.
- Basic and major services are covered at 80% for individual coverage and 60% for family coverage with a $25 deductible for family coverage (based on the Usual Customary Rates (UCR) for Alabama). These services include: fillings, general anesthetics, oral surgery not covered under a Group Medical Program, periodontics, endodontics, dentures, bridgework, and crowns.
- The family coverage deductible for basic and major services is applied per person, per plan year with a maximum of three (3) per family.
- All dental services are subject to a maximum of $1,250 per plan year for individual coverage and $1,000 per person per plan year for family coverage. Dental coverage does not cover pre-existing dentures or bridgework, nor does it provide orthodontia benefits.
- **The dental coverage does not cover the replacement of natural teeth removed before a member's coverage is effective.**
- This plan does not cover temporary partials, implants, or temporary crowns.
- The dental plan administered by Southland National offers a money-saving network program known as DentaNet. Under the DentaNet program, members have the opportunity to use network dentists but still have the freedom to use any dentist.
- To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers.
- Dental benefits under this plan will always be paid secondary to other dental plans.

Hospital Indemnity Plan

- This plan provides a per-day benefit when the insured is confined to the hospital.
- The In-hospital benefit is $150 per day for individual coverage and $75 per day for family coverage.
- In-hospital benefits are limited to 365 days.
- Intensive care benefit is $300 per day for individual coverage; $150 per day for family coverage.
- Convalescent care benefit is $150 per day for individual coverage; $75 per day for family coverage.
- Convalescent care benefits are limited to a lifetime benefit of 90 days. This plan does not cover assisted living facilities.
- Cancer and maternity admissions are covered as any other illness.
- There is supplemental accident coverage for $1,000. The reimbursement for an accident(s) is limited to a maximum of $1,000 per contract year for each covered individual. There is no limit on the number of accident claims that can be filed per contract year.

Vision Care Plan

This plan provides coverage for:

- One examination in any 12-month period (actual charges up to $40)
- One new prescription or replacement prescription for lenses per plan year (up to $50 for single vision, $75 for bifocals, $100 for trifocals, and $125 for lenticular)
- One new prescription or replacement of contacts per plan year (up to $100 for contact lenses)
- One new or replacement set of frames per plan year (up to $60)
- Either glasses or contacts, but not both in any plan year
- Disposable contact lenses
- Vision benefits under this plan will always be paid secondary to other vision plans.

Remember, this is only a summary of benefits. Members should refer to the appropriate benefit booklet for detailed information and limitations.

PEEHIP Supplemental Coverage Plan

The supplemental Hospital Medical Plan will:

- Provide secondary coverage to the members and covered dependent(s) when primary coverage is provided by another employer.
- Only active and non-Medicare-eligible retiree members and dependents are eligible to enroll in the Supplemental Plan.
- There is no premium cost for the plan when the member uses the state allocation for the Supplemental Plan.
- The Supplemental Plan covers most deductibles, copayments, and coinsurance not covered by the primary plan.
- Participants may elect individual or family coverage.

- PEEHIP Hospital Medical Plan exclusions and limitations will continue to be imposed such as exclusions for dental coverage, cosmetic surgery, limitation on infertility treatment, etc.
- The Supplemental Plan will not cover or pick up any cost of services excluded by the primary plan because the plan is strictly a supplemental plan.
- The Supplemental Plan cannot be used as a supplement to Medicare, the PEEHIP Hospital Medical Plan, or the State or Local Governmental plans administered by the State Employees' Insurance Board (SEIB).
- The Supplemental Plan only supplements your primary insurance plan by covering the copay, deductible and/or coinsurance of your primary insurance plan or the preferred/participating allowance, whichever is less.
- To be eligible for reimbursement under the PEEHIP Supplemental Coverage Plan, the primary insurance plan must have either 1) applied the eligible charges to the deductible, or 2) made primary payment for the services rendered.
- For inpatient mental health and substance abuse services, there is a maximum allowance of 30 total days per member per plan year.
- For outpatient mental health and substance abuse services, there is a maximum allowance of 10 visits per member per plan year.
- The PEEHIP Supplemental Coverage Plan will not pay for amounts in excess of the allowed amount for services rendered by a non-preferred provider, amounts in excess of the maximums provided under the primary insurance plan, any services denied by the primary insurance plan, or any penalties or sanctions imposed by the primary insurance plan.
- PEEHIP members cannot be enrolled in the PEEHIP Hospital Medical Plan and the PEEHIP Supplemental Plan.
- Active members who have TriCare or Champus as their primary insurance coverage cannot enroll in the PEEHIP Supplemental Plan.

PEEHIP Children's Health Insurance Program (CHIP)

The following outlines PEEHIP's policies and procedures for determining when children of PEEHIP members qualify for CHIP:

- Member must be enrolled in the individual PEEHIP Hospital Medical Plan.
- Member cannot carry family PEEHIP Hospital Medical Plan and CHIP.
- Member must complete the CHIP application form located in the back of this packet and return the form to the PEEHIP office within 30 days of his or her employment date or before August 31 if during the Open Enrollment period.
- Children must be under 19 years of age, eligible for the PEEHIP Hospital Medical Plan coverage, and not in an institution.
- PEEHIP does not cover maternity benefits for dependent children in the PEEHIP Hospital Medical Plan or in CHIP. In addition, PEEHIP does not cover dental or vision benefits in the PEEHIP Hospital Medical Plan or in CHIP.
- Application must be received during Open Enrollment or at the time of a qualifying event that would allow adding or deleting family coverage outside of Open Enrollment or within 30 days of a new employee's date of employment.
- Application must be accompanied by a complete, signed copy of the member's latest Federal Income Tax Return, along with copies of all pertinent W-2's and 1099's. If the member is married but filed a separate return, a copy of the spouse's latest Federal Income Tax Return, along with copies of all pertinent W-2's and 1099's, is also required.
- Application is prescreened for accuracy of the income records in relation to the income reported to the TRS for the member.
- Application is prescreened to determine if the child/children are covered by Medicaid. If the child/children are covered by Medicaid, they are not eligible for CHIP coverage.
- Family size is determined by the total number of persons who are exemptions on the Federal Tax Return.
- Income is determined as Total Income before any adjustment or deductions on the Federal Tax Return.
- The income range for qualifying for CHIP is 100% to 200% of the current Federal Poverty Level per family size. The Federal Poverty Level by family size is updated annually in February. PEEHIP will update the ranges used each Open Enrollment with the most current ranges issued.

- If the applicant is determined to be under the income/family size qualification, the applicant will be notified of potential Medicaid eligibility.
- If the applicant is determined to be within the income/family size qualifications, the applicant's children under age 19 will be enrolled in CHIP.
- The yearly premium is $50 per child with a maximum of $150 yearly premium for three (3) or more children.
- If the application is determined to be over the income/family qualification, the applicant will be notified that he or she does not qualify for CHIP.
- Enrollment in CHIP is only applicable for the year ending each September 30. **Members must re-enroll each Open Enrollment.**
- Coverage in PEEHIP CHIP will terminate on the last day of the month in which any of the following events occur: covered child is no longer eligible as a dependent under CHIP, death of the covered child, nineteenth birthday of the covered child, notification to PEEHIP that covered child becomes covered by other health insurance, member enrolls in the family PEEHIP Hospital Medical Plan or member terminates employment and, as a result, enrolls in PEEHIP COBRA.

Coordination of Benefits

If an employee or covered dependent is enrolled in the dental and/or vision plans provided by PEEHIP and is also entitled to any other dental or vision coverage, the total amount that is payable under all plans will not be more than 100% of the covered expenses. In addition, PEEHIP will coordinate benefits with other dental and vision coverages. A member must correctly complete the Group Health Insurance Coverage Information section of the Health Insurance and Optional Enrollment Application or provide the information using the Member Online Services system and update PEEHIP when changes are made.

Members and dependents are legally required to notify PEEHIP of other coverage. Also, systems must inform PEEHIP when other insurance coverage of any kind is provided to employees by their system.

Claims incurred and filed on the PEEHIP dental and vision plans administered by Southland National are always paid secondary to other dental and vision plans.

Flexible Spending Accounts

(Administered by Blue Cross and Blue Shield of Alabama)

The PEEHIP Flexible Spending Accounts program is available to all active members of PEEHIP. Retired members are not eligible to participate in any of the Flexible Spending Accounts. The PEEHIP Flexible Spending Accounts consist of the following programs:

Premium Conversion Plan requires all active members to pay premiums for PEEHIP using pre-tax dollars. This plan is strictly a function of the payroll system in which the member no longer has to pay federal and state of Alabama income taxes on their health insurance premium. All active members participate in the Premium Conversion Plan.

1. **Dependent Care Flexible Spending Account** allows eligible active members the opportunity to pay dependent care expenses using pre-tax dollars.
2. **Health Care Flexible Spending Account** allows eligible employees to set aside tax-free money in an account to pay themselves back for eligible health care expenses incurred by them and their dependents.

Blue Cross and Blue Shield of Alabama administers both Spending Accounts.

The Open Enrollment deadline for the Flexible Spending Accounts is September 30, for an effective date of October 1. Members who are currently enrolled in a Flexible Spending Account through their employer are allowed to enroll in the PEEHIP spending accounts at the end of their employer's plan year. **All members currently enrolled in the PEEHIP Flexible Spending Accounts must re-enroll every year.** These programs do not automatically renew each year.

To enroll in the Flexible Spending Accounts, members can 1) enroll online through Member

Online Services at www.rsa-al.gov; or 2) complete the Flexible Spending Account Enrollment Application located in the back of this packet. The online or paper form must be submitted to the PEEHIP office prior to October 1 or within 30 days of their date of employment. More information is available at www.bcbsal.org/peehip1/preferredBlue/index.cfm.

New employees who are hired during the Open Enrollment period can enroll in a Flex account, and the effective date will be October 1. If a new employee is hired after October 1 and before July 1, the effective date of the Flex account must be the first day of the first full month after the date of hire. Example: If the hire date is November 7, the Flex account effective date must be December 1.

Listed below are some of the eligible expenses that can be paid from your Flexible Benefits Account:

Health Care Flexible Spending Account

- Prescription drug copays as well as over-the-counter medications
- Physician copays
- Vision care including Lasik and Prelex surgery
- Hearing care
- Deductibles
- Orthodontia
- Coinsurance

Dependent Care Flexible Spending Account

- Licensed nursery school and day care facilities for children
- Child care in or outside your home
- Day care for an elderly or disabled dependent

To determine how much per year you want to contribute to your Flexible Spending Account(s), you should assess what your expenses were the year before and determine if these expenses will occur again and then add in any new expenses. Your annual contributions must be whole dollars. The funds are deducted from your pay before taxes are withheld and deposited into your account.

PEEHIP has set an annual minimum contribution amount of $120 and a maximum of $5,000 per plan year for the **Health Care Flexible Spending Account**. The **Dependent Care Flexible Spending Account** has a minimum contribution of $120 and a maximum amount of $5,000 if single or married filing a joint return or a maximum amount of $2,500 if married filing separate returns.

If your medical and/or dental insurance is with any PEEHIP Hospital Medical or Optional Plan, your out-of-pocket expenses for medical and/or dental services will automatically apply to your Flexible Spending Accounts. If you have medical, dental or secondary coverage with another insurance plan, you will need to file a Request for Reimbursement form with appropriate documentation and provide documentation of what the other carrier paid.

The out-of-pocket money is reimbursed to you from your account. You may even elect to have it deposited directly into your checking or savings account.

Amounts unused and unspent in the Health Care Flexible Spending Account as of September 30 can be used to pay for out-of-pocket medical expenses incurred during the 2 ½ month grace period ending December 15. Expenses for both the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account can be submitted to Blue Cross by January 15 following the end of the plan year.

If you terminate employment or retire before the end of the plan year, your Flexible Spending Accounts will terminate the first day of the following month.

When a member retires or terminates employment before the end of the plan year, the member must use or incur the money in his or her Flex account by the Flex termination date. For example, if a member retires June 1, 2008, and the Flex account terminates September 1, 2008, the member must incur the covered expenses by September 1, 2008. Claims must be filed within 105 days from the end of the plan year.

Federal Poverty Level Assistance Program (FPL)

PEEHIP provides premium assistance to PEEHIP members with a combined family income of less than or equal to 200% of the Federal Poverty Level (FPL) as defined by federal law. To qualify for FPL assistance, PEEHIP members must furnish acceptable proof of total income based on their most recently filed Federal Income Tax Return. Certification of income level will be effective for the plan year only. Re-certification will be required annually during Open Enrollment. The premium reduction does not automatically renew each year. The premium reduction will apply only to the Hospital Medical premium or HMO premium and only applies to active and retired members. The FPL premium discount is not available to members who are on a Leave of Absence, COBRA, or surviving spouse contract.

Federal Poverty Level Premium Discount:		
Over 200% of the FPL	member pays 100% of the member contribution	
equal to or less than 200% but more than 175% of the FPL	member contribution reduced 10%	Member pays 90%
equal to or less than 175% but more than 150% of the FPL	member contribution reduced 20%	Member pays 80%
equal to or less than 150% but more than 125% of the FPL	member contribution reduced 30%	Member pays 70%
equal to or less than 125% but more than 100% of the FPL	member contribution reduced 40%	Member pays 60%
equal to or less than 100% of the FPL	member contribution reduced 50%	Member pays 50%

2008 Federal Poverty Levels (FPL)					
Family Size	**100% of FPL**	**125% of FPL**	**150% of FPL**	**175% of FPL**	**200% of FPL**
1 member	$10,400	$13,000	$15,600	$18,200	$20,800
2 members	$14,000	$17,500	$21,000	$24,500	$28,000
3 members	$17,600	$22,000	$26,400	$30,800	$35,200
4 members	$21,200	$26,500	$31,800	$37,100	$42,400
5 members	$24,800	$31,000	$37,200	$43,400	$49,600
6 members	$28,400	$35,500	$42,600	$49,700	$56,800
7 members	$32,000	$40,000	$48,000	$56,000	$64,000
8 members	$35,600	$44,500	$53,400	$62,300	$71,200
Each additional person, add	$3,600	$4,500	$5,400	$6,300	$7,200

Premium Rates

Payment of Premiums

- PEEHIP premiums for health insurance and optional plans are deducted in the month prior to the month of coverage for active and retired members (i.e. the premium for October's insurance coverage is deducted in September).
- Flexible spending account contributions are deducted in the current month and are based upon twelve month deduction cycles (i.e. the contribution for October is deducted in October).
- Those who do not receive a check large enough to cover the amount of their total premium shall submit their monthly premium payment directly to PEEHIP (i.e. new employees who have not begun receiving a paycheck; those covered under COBRA; members on Leave of Absence; etc.).
- **Failure to pay premiums timely will result in cancellation of coverage.**

PEEHIP Premium Rates 2008 – 2009 Plan Year

The following monthly premiums are effective October 1, 2008 - September 30, 2009. **These premium rates do not include the $23.00 monthly tobacco surcharge.**

Active Members

PEEHIP Hospital Medical or Viva Health Plan			
Coverage		Allocation - Cost to State	Monthly Out-of-Pocket Cost
Single	$754	$752	$ 2
Family	$886	$752	$134

COBRA and Leave of Absence Rates	
Single	$365
Family	$868

Retired Members

The premiums listed in the charts below show the retiree's out-of-pocket cost after subtracting the retiree allocation. These rates apply only to members who retired prior to October 1, 2005, or members who retired on or after October 1, 2005, with 25 years of service. All members who retired on or after October 1, 2005, are subject to the Retiree Sliding Scale premium based on years of service. These retirees may experience a rate adjustment effective October 1, 2008. The premium rates can be found on the PEEHIP Web site at **www.rsa-al.gov**, click **PEEHIP**, then go to **Premiums**. **Also, non-Medicare members and dependents may experience a modest increase premium rates effective January 1, 2009.**

Retired Member Rates		
Type of Contract	*Retiree Monthly Out-of-Pocket Premium	Cost to State on Behalf of the Retiree
Individual Coverage/ Non-Medicare Eligible Retired Member	$ 97.54	$487.46
Family Coverage/Non-Medicare Eligible Retired Member and Non-Medicare Eligible Dependent(s)	$284.94	$813.06
Family Coverage/Non-Medicare Eligible Retired Member and only Dependent Medicare-Eligible	$188.54	$698.46

Retired Member Rates		
Type of Contract	***Retiree Monthly Out-of-Pocket Premium**	**Cost to State on Behalf of the Retiree**
Individual Coverage/ Medicare Eligible Retired Member	$ 1.14	$288.86
Family Coverage/Medicare Eligible Retired Member and Non-Medicare Eligible Dependent(s)	$188.54	$614.46
Family Coverage/Medicare Eligible Retired Member and only Dependent Medicare-Eligible	$ 92.14	$499.86

**This rate applies to the PEEHIP Hospital Medical or the VIVA Health Plan HMO and is the monthly amount that will be deducted from a retiree's check. If more than one dependent is Medicare-eligible, you must pay premiums for multiple dependents.*

Retired Members Combining Allocations Rates		
Out-of-Pocket if Retiree and Retired Spouse Combine Allocations	***Retiree Monthly Out-of-Pocket Premium**	**Cost to State on Behalf of the Retiree**
Retiree <65 Dependent <65	$164.94	$933.06
Retiree <65 Dependent >65	$ 68.54	$818.46
Retiree >65 Dependent <65	$ 68.54	$734.46
Retiree >65 Dependent >65	$ 0.00	$592.00

**This rate applies to the PEEHIP Hospital Medical or the VIVA HMO Plan and is the monthly amount that will be deducted from a retiree's check. The VIVA HMO Plan is not available to retired members who are Medicare eligible or dependents who are Medicare eligible.*

If a husband or wife retired on or after October 1, 2005, and they choose to combine their insurance allocations and carry family coverage, the out-of-pocket costs must be calculated by a PEEHIP or TRS counselor because of the infinite combinations of rates. It is usually more cost effective for a husband and wife who are both PEEHIP eligible to combine their allocations and carry family coverage instead of carrying two individual policies.

The state allocation can be used to purchase the PEEHIP Supplemental Plan or **two** Optional Plans at no cost to the retiree if the retiree is not using the allocation for one of the Hospital Medical Plans or combining allocations. Additional optional plans can be purchased for $38.00 per month per plan. Full-time active members can use their allocation to purchase the PEEHIP Supplemental Plan or **four** Optional Plans in lieu of the Hospital Medical Plan.

PEEHIP Supplemental Plan Rates	
Single or Family	$0
COBRA and Leave of Absence Rates for the Supplemental Plan	
Single or Family	$115

Optional Coverage:	Active and Retired Members	
Cancer	$38/month	Individual or Family Coverage
Indemnity	$38/month	Individual or Family Coverage
Dental	$38/month	Individual or Family Coverage
Vision	$38/month	Individual or Family Coverage

Medicare rules require a Medicare-eligible, active PEEHIP member who is covered on their spouse's PEEHIP **retired** contract to have Medicare as the primary payer on the active PEEHIP member. Therefore, the active, Medicare-eligible member will need Medicare Part A and Part B coverage.

If the active member does not want Medicare as his or her primary payer and does not want to enroll in Medicare Part B until retirement, he or she will have to enroll in a PEEHIP **active** contract and will not be able to combine allocations with the retired PEEHIP-eligible spouse. Most of the time, in this situation, active members must wait and enroll in their own PEEHIP medical policy during the Open Enrollment period or on their spouse's date of retirement. When the active Medicare-eligible member retires, he or she will need to enroll in Medicare Part B. The effective date of Medicare Part B needs to be the date of retirement to avoid a lapse in coverage.

Note: If a member or dependent is under age 65 and eligible for Medicare coverage due to a disability, PEEHIP must receive a copy of the Medicare card before the premiums can be reduced. However, PEEHIP will pay secondary to Medicare once our office becomes aware of your Medicare eligibility regardless of whether our office has received your Medicare card. Medicare-eligible members and dependents should have Medicare Part A and Part B to have adequate coverage with PEEHIP.

Comparison of Benefits

Effective October 1, 2008 – September 30, 2009

(changes are in bold)

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan HMO* (In approved areas only) (Available for Active and Non-Medicare Members Only.)
Preventive Medical	$20 copayment then covered in full	$15 copayment then covered in full
Well Baby Care	$20 copayment per visit (6 visits 1st year; 1 visit/yr. thru age 6; one exam every 2 yrs ages 7 - 18)	$15 copayment then covered in full
Routine Immunizations	$20 copayment then covered in full	$15 copayment then covered in full
Office Care		
Physician's Care	$20 per visit	$15 per visit for primary care. $30 for specialty care. Referrals are no longer necessary.
Lab Procedure	$3 per test	Covered in full (after office visit copayment)
Maternity		
Physician's Care	Covered in full	$30 copayment (initial visit only) then covered in full
Inpatient	$100 hospital copayment	Covered in full after $200 copayment
Hospital Services	$100 copayment per admission	$200 copayment per admission
Outpatient Surgery	$75 copayment	$75 copayment, then covered in full
In-Hospital Care		
Surgeon	Covered in full	Covered in full
Physician Visits	Covered in full	Covered in full
Anesthesiologist	Covered in full	Covered in full
Emergency		
In Area/Out of Area Emergency Room	$25 per visit, accident within 72 hours covered 100%	$50 emergency room visit for facility, waived if admitted within 24 hours; Physician's charges covered at 100%.

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan HMO* (In approved areas only) (Available for Active and Non-Medicare Members Only.)
Mental Health and Substance Abuse		
Inpatient	Copayments: Days 1-9 $0, days 10-14 $15, days 15-19 $20, days 20-24 $25, days 25-30 $30. Maximum of 30 days per member per fiscal year at approved facilities. Limit of one substance abuse admission per year and two admissions per lifetime.	Mental Health covered at 50%. Maximum benefit for mental health is 30-day combined maximum for mental health/substance abuse per calendar year. Substance abuse is limited to detox only. Maximum of 3 days/occurrence with 50% coverage.
Outpatient	$10 copayment for up to 20 outpatient visits at approved facilities.	100% coverage after $50 copayment per visit. Subject to 20-visit combined maximum for mental health/substance abuse per calendar year.
Prescription Drugs	(Administered by Express Scripts.) Generic - $5 copayment Formulary (preferred brand name) drugs $30 copayment. Non-formulary (non-preferred brand name) drugs $50 copayment. Approved Maintenance drugs covered for 90-day supply. First fill for a new maintenance drug will be a 30-day supply. **Certain medications have quantity level limits to comply with the FDA guidelines and to ensure drug safety for our members.** **Certain medications are subject to Step Therapy.** **Prior authorizations are required before covered members can receive certain medications.** No benefits available when a non-participating pharmacy in the State of Alabama is used. Out-of-State non-participating pharmacies are paid at the participating pharmacy rate. Members pay difference in cost plus appropriate copayments. Pharmacists must dispense generic drug unless physician indicates in longhand writing on the prescription “Do Not Substitute”, “Medically Necessary”, or “Dispense as Written.”	Generic - $12 copayment Brand Name - *$25 preferred brand (formulary) *$45 non-preferred (non-formulary) *When an appropriate grade generic is available and brand name is chosen, the copayment will be the brand name copayment plus the cost differential between the brand and generic drugs. 50% coverage for Mental Health drugs. 90% coverage for self-administered injectibles, bio-technical and biological drugs. $3,000 maximum payment in drug costs, per calendar year, per person. Participating pharmacies only. Mail Order pharmacy is available. Oral contraceptives are covered subject to the appropriate copayment.
Other Services		
Out-of-state Coverage for Non-PPO Provider	Major Medical benefits apply - payable at 80% UCR after $100 yearly deductible	Only Emergency and Urgent Care Services and Prescription Benefits available

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan HMO* (In approved areas only) (Available for Active and Non-Medicare Members Only.)
Out-of-state Coverage for PPO Provider	$20 copayment per visit. Members must use providers participating in the Blue Cross plan of that state.	N/A
Vision Examinations	Not Covered	Covered in full once each 12 months after a $30 copayment with participating provider
Dental	Not Covered	The Dental Plan allows you to seek treatment from any licensed dentist. The plan reimburses a percentage of eligible expenses based on usual, customary and reasonable (UCR) fees. **Beginning October 1, 2008, the VIVA dental benefits will be administered by Delta Dental.** Type I – Preventive & Diagnostic – 100% of UCR Type II – Basic Services – 50% of UCR Type III – Major Services** - 25% of UCR Deductible (applies to Basic & Major Services) - $50 per person/$150 per family Calendar Year Max - $500 **12-month Waiting Period applies to Major Services
Spinal Service & Chiropractic Services	Participating Chiropractor – Covered at 80% of the allowed amount with no deductible. After 12 visits in a calendar year, services are subject to precertification. Non-participating Chiropractor- Covered under major medical at 80% of allowed amount. Member will owe 20% co-insurance, major medical deductible and charges over allowed amount.	Limited to 10 visits per calendar year $30 copayment per visit
Infertility Services	Benefits for medically necessary infertility services are available for artificial insemination and related services. Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum payment of $2,500 for PEEHIP per member contract. Members will pay 100% of the medications after the $2,500 lifetime maximum is reached. Benefits are not provided for Assisted Reproductive Technology (ART).	Coverage for infertility services is limited to initial consultation and one counseling session only. Testing is limited to semen analysis, HSG and endometrial biopsy (covered once during the Member's lifetime). Treatment for infertility is not a Covered Service.

** VIVA Health Plan HMO: No referral from a primary care physician (PCP) is required. Members must use participating physicians and specialists. Members must use participating hospitals.*

***Time served on a prior carrier's dental plan with your current employer may be credited towards this plan's waiting periods, subject to Underwriting approval.*

Updating Information

Name and Social Security Number Changes

Currently, PEEHIP determines a member's name for insurance purposes from the TRS Form 100 Enrollment form, or the Health Insurance and Optional Enrollment Application. In the near future, PEEHIP will be updating names from information received from the Social Security office. Therefore, the name on all insurance and TRS forms must be the same as the name on the Social Security card.

PEEHIP requires a copy of the member's Social Security card before a name or Social Security number change can be made. Also, active employees must provide a correct Social Security card to their employer to correct their TRS and PEEHIP accounts.

Address Changes

To change an address, a member must notify PEEHIP in writing or update their address through the online process. To change your address in writing, you should complete an Address Change Notification form which can be downloaded from the RSA Web site. PEEHIP will also accept a letter with the old address, new address, insured's name and Social Security number.

The PEEHIP department cannot accept an address change by phone. All address changes should be made on the address change cards provided by the U.S. Postal Service or the Address Change Notification form provided by RSA. The card must then be mailed to PEEHIP for the actual change to occur.

To change your address online, go to the RSA Web site at www.rsa-al.gov and make an address change. Select the **Member Online Services** option on the left side of the home page and follow the instructions. This address change will automatically transmit to the insurance carriers and also update your address with the Teachers' Retirement System and RSA-1 if you are a participant in those accounts. However, the address change you make through the RSA online system will not change your address with your employer. You must contact your employer to have your address changed in their system.

Allocations

An active member receives the state insurance allocation for each month the member is in pay status at least one-half of the working days of that month.

Allocations are earned in the actual month worked.

Example:

An employee who works October 1 through November 8 earns the October allocation but not the November allocation.

An employee may get paid for a portion of a month but may not earn the allocation for that month if he or she is not in pay status at least one-half of the workdays of that month.

To be eligible for a full allocation, a teacher, counselor, librarian, administrative employee or other professional employee must be employed full-time. A support worker, such as janitorial staff employee, custodian, maintenance worker, lunch room worker, or teacher aide, must be employed at least twenty (20) hours per week (excluding bus drivers who are full-time by law) to receive a full allocation. Permanent part-time employees who meet the qualifications will be entitled to a pro rata allocation.

	Allocation Entitlement if Enrolled in Hosp/Med or HMO Plan	Allocation Entitlement if Enrolled in Optional Plans
Professional/Administrative Employee Works		
Less than ¼ time	0	0
At least ¼ time but < ½ time	¼ insurance allocation	1 Plan
At least ½ time but < ¾ time	½ insurance allocation	2 Plans
At least ¾ time but < Full-time	¾ insurance allocation	3 Plans
Full-time	Full allocation	4 Plans
	(Each additional optional plan can be purchased for $38.00/month.)	
Support Worker Works		
0 to 4.9 hours/week	0	0
5.0 to 9.9 hours/week	¼ insurance allocation	1 Plan
10.0 to 14.9 hours/week	½ insurance allocation	2 Plans
15.0 to 19.9 hours/week	¾ insurance allocation	3 Plans
20 or more hours/week	Full allocation	4 Plans
	(Each additional optional plan can be purchased for $38.00/month.)	

Leave

A member can use his or her accrued or donated sick leave in order to be in pay status to receive the state allocation. However, sick leave, annual leave, or catastrophic leave cannot be manipulated in such a way that a member receives the allocation inappropriately. **A member must use his or her accrued sick leave, annual leave or catastrophic leave continuously and consecutively when not actively employed.**

3-1 Rule

A member earns **one** month of an additional insurance allocation for every **three** months the employee is in pay status at least one-half of the workdays in the month for that school year. The 3-1 Rule only applies when an employee has terminated employment, retires, is not in pay status at least one-half of the work days in the month, goes on an approved leave of absence without pay, or begins employment in the middle of the year.

The 3-1 Rule is applied using a September through September year.

- Extra allocations earned by a member must be applied to insurance premiums immediately after the member is separated from employment.
- The member cannot pick and choose the months to use the allocation.
- An employee must be in pay status at least one-half of the available workdays for three full months to earn an extra one month of an insurance allocation.
- An employee can only use the earned allocation credit for the current fiscal year, i.e., the allocation credit cannot be used after September 30.
- The 3-1 Rule is handled in the same manner for all employees regardless of whether they are paid on a 9-, 10-, 11- or 12-month basis.

The table below should be used when calculating the number of months an employee is entitled to receive the insurance allocation:

Actual Service (months)	Earned Allocation(s)
1	1
2	2
3	4
4	5
5	6
6	8
7	9
8	10
9	12
10	12
11	12
12	12

Terminated Employee

The system is not required to pay the September allocation for an employee terminating the end of May when the employee has worked September through May. These employees have earned the insurance allocation through August and should not be given credit for the September insurance allocation.

Additional Information about Insurance Allocations

An allocation for the month will be due if a member is hired on the first day of the month. An allocation can be used for the month of September. Example: An employee has been in hire status for 9 consecutive months and terminates employment after June 16. The member will have an allocation to burn for July, August, and September.

A full August allocation is due if the member has had continuous coverage through the summer. A member who has paid a LOA rate or COBRA for July and returns to work after August 1 but prior to August 15 is entitled to a full August allocation.

Insurance is deducted one month in advance. An enrollment request for insurance to begin the first date of hire should be accompanied with a personal check.

Family Medical Leave Act (FMLA)

The 3-1 Rule applies even when a member is granted leave under the Family Medical Leave Act. If the employee earns additional allocations under the 3-1 Rule prior to going on leave under FMLA, the extra allocations are applied to the months following said leave.

Military Leave

If an employee is on military leave status, the employee earns credit for the insurance allocation which is paid by the PEEHIP Plan. The employer will not be charged for the insurance allocation when a member is on military leave status in the Employer Online Services.

Death

Extra insurance allocations earned under the 3-1 Rule can only be used by the employee and cannot be used by the employee's family in the event of the employee's death. If a husband and wife are combining allocations and one member dies, the living spouse cannot use the deceased member's extra allocation earned.

Retiring Members

Retiring members are eligible to receive the extra allocations earned under the 3-1 Rule.

Example:

- A June 1 retiree who works 9 months during the school year earns extra allocations through August 31.
- A July 1 retiree who works the entire school year earns extra allocations through September 30.

The school system is required to provide the appropriate insurance allocation earned under the 3-1 Rule. PEEHIP assumes that the system will not pay the September allocation for June 1 retirees in most cases. June 1 retirees should continue to receive the active allocation through August.

The 3-1 Rule is handled in the same manner for retirees as for active employees regardless of whether they are paid on a 9-, 10-, 11- or 12-month basis.

Transferred Allocations and Combined Allocations

Transferred Allocations

- Employees can transfer the state allocation to a spouse who is employed with a PEEHIP participating system.
- An employee may not transfer the state allocation to a spouse who is employed with a non-participating system.
- A retired member's allocation cannot be transferred to an active member.
- A retired member can accept the active spouse's allocation.

Combined Allocations

When two eligible active employees, both covered under PEEHIP, elect to combine their allocations, no premium remittance is required for family Hospital Medical coverage. However, if these employees are also enrolled in Optional Plans, they are required to pay those premiums and must pay the tobacco charge, if applicable. Any surplus premium cannot be applied to the cost of purchasing Optional Plans.

Within 30 days of employment or marriage, a husband and wife must notify PEEHIP of their intent to combine allocations. This must be done in writing using the Health Insurance and Optional Status Change form.

Members and spouses can only begin combining insurance allocations at the following times:

1. October 1,
2. First day of the month following marriage (only if employees are enrolled in Hospital Medical Plan at the time of marriage and not enrolled in the Optional Plans), or
3. First day of the month following employment. If a new employee starts to work on the 1st day of the month, the employee and spouse can begin combining allocations on the 1st day of that month only if the spouse is already enrolled in family coverage.

Example:
If either the employee or spouse who is combining allocations dies or the couple gets a divorce, the employee cannot continue to get credit for the spouse's allocation. However, in the case of a member or spouse terminating employment or going on an approved leave of absence, the employee or spouse gets credit under the "3-1" rule for any extra earned allocations.

Husband and wife cannot begin combining allocations after the birth of a child.

Transferring School Systems

When an employee transfers from one participating system to another without a break in coverage, the **new** system will be responsible for paying the allocation the **first full month** of the employee's contract.

Active Employees Not Enrolled in Coverage

Section 16-25A-9, *Code of Alabama, 1975*, requires the insurance allocation amount must be paid for all employees eligible for insurance even if no coverage is elected.

Example:
A new employee begins work August 23 and does not enroll in coverage until October 1.

PEEHIP would not require the system to pay the pro rata allocation for August if the employee does not elect coverage on his date of employment; **however, PEEHIP would require the insurance allocation amount for the full month of September.**

Members who are not enrolled in any insurance coverage are allowed to enroll in single medical coverage effective on the date of notification. Those members will be required to serve a 270-day waiting period on pre-existing conditions unless proof of previous coverage is provided and approved.

Employers are not required to pay the pro rata insurance allocation for a new employee if the employee does not enroll in insurance coverage on his date of employment. However, Section 1625A-9, Code of Alabama, 1975 requires the insurance allocation to be paid for a full month of coverage even if the employee does not enroll in any coverage.

Medicare

If a member or dependent is already Medicare-eligible due to age or disability at the time of his or her retirement, Medicare will become the primary payer and PEEHIP the secondary payer **effective on the date of the member's retirement.**

It is extremely important for the member and/or dependent to have Medicare Part A and Part B to assure adequate coverage with PEEHIP. The member will continue to earn the active allocation according to the 3-1 Rule, but Medicare will be the primary payer for claims beginning the date of retirement for Medicare-eligible members or dependents. If the member and only dependent are both eligible for Medicare, the reduced Medicare out-of-pocket cost will be deducted.

If a Medicare-eligible, active PEEHIP member is covered by his or her spouse's PEEHIP retired contract, Medicare must be the primary payer on the active PEEHIP member. The active, Medicare-eligible member will need Medicare Part A and Part B coverage.

If the active member does not want Medicare as his or her primary payer and does not want to enroll in Medicare Part B until retirement, he or she will have to enroll in a PEEHIP **active** contract and will not be able to combine allocations with the retired PEEHIP-eligible spouse. Most of the time, in this situation, active members must wait and enroll in their own PEEHIP medical plan during the Open Enrollment period or on their spouse's date of retirement. When the active Medicare eligible member retires, he or she will need to enroll in Medicare Part B. The effective date of Medicare Part B needs to be the date of retirement to avoid a lapse in coverage.

Most Medicare-eligible retirees and covered dependents should not enroll in the Medicare Part D coverage if they are covered by the PEEHIP Medicare Plus plan.

Surviving Dependent Benefits

PEEHIP law allows covered surviving dependents to be able to continue the PEEHIP insurance plans that they are covered on at the time of the member's death.

The insurance plan(s) can be continued as long as the surviving dependents pay the monthly premium by the due date each month.

Survivor policies are as follows:

- New dependents who are not covered on the PEEHIP policies at the time of the member's death cannot be added to the plan at a later date.
- Surviving dependents do not have Open Enrollment rights.
- Once the insurance is cancelled by a surviving dependent, no reinstatement is allowed, and coverage cannot be picked up at a later date.
- Surviving dependents cannot enroll in **new** PEEHIP plans that they were not covered on at the time of the member's death.

PEEHIP law also requires surviving dependents to pay the full cost of the monthly premium without financial assistance from the state. The monthly premiums effective October 1, 2008, are as follows:

Premium Rates for Surviving Dependents October 1, 2008 - September 30, 2009	
Type of Contract	**Monthly Premium for PEEHIP Hospital Medical or the VIVA HMO Plan**
Individual Coverage/Non-Medicare-eligible Survivor	$585.00
Individual Coverage/Medicare-eligible Survivor	$290.00
Family Coverage/Non-Medicare-eligible Survivor and Non-Medicare Eligible Dependent(s)	$717.00
Family Coverage/Non-Medicare-eligible Survivor and Only Dependent Medicare-eligible	$676.00
Family Coverage/Medicare-eligible Survivor and Non-Medicare-eligible Dependent(s)	$422.00
Family Coverage/Medicare-eligible Survivor and Only Dependent Medicare-eligible	$381.00
Optional (Each)	$ 38.00

Note: If a member or dependent is under age 65 and eligible for Medicare coverage due to a disability, the PEEHIP office must receive a copy of the Medicare card before the premiums can be reduced. However, PEEHIP will pay secondary to Medicare once our office becomes aware of your Medicare eligibility regardless of whether our office has received your Medicare card. Medicare-eligible members and dependents should have Medicare Part A and Part B to have adequate coverage with PEEHIP.

Optional Coverage:		
Cancer	$38.00/month	Individual or Family Coverage
Indemnity	$38.00/month	Individual or Family Coverage
Dental	$38.00/month	Individual or Family Coverage
Vision	$38.00/month	Individual or Family Coverage

Provision for Medicare-Eligible Members

Active Employees

PEEHIP is required by the Age Discrimination in Employment Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982, to offer its active employees over age 65 coverage under its group health plan under the same condition as any employees under age 65. As a result of an accompanying amendment to the Social Security Act, Medicare is secondary to benefits payable under an employer-sponsored health insurance plan for employees over age 65 and their spouses over age 65. If the service is also covered by Medicare, the claim can be submitted to Medicare which may pay all or a portion of the unpaid balance of the claim subject to Medicare limitations.

As a result of these changes, PEEHIP does not provide an active member or his or her spouse with benefits which supplement Medicare. The member has the right to elect coverage under PEEHIP on the same basis as any other employee.

If a member chooses to be covered under PEEHIP, the plan will be the primary payer for those items and services covered by Medicare. (Note that Medicare covers hospitalization, post-hospital nursing home care, home health services.) This means that the plan will pay the covered claims and those of the member's Medicare-eligible spouse first, up to the limits contained in the plan, and Medicare may pay all or a portion of the unpaid balance of the claims, if any, subject to Medicare limitations. If the member's spouse is not eligible for Medicare, the plan will be the sole source of payment for the spouse's claims.

Since PEEHIP also covers items and services not covered by Medicare, PEEHIP will be the sole source of payment of medical claims for these services.

Because of the cost of Medicare Part B, a member age 65 or older may decide to defer enrolling for Part B until he or she actually reaches retirement, at which point Medicare will become the primary payer and the member will need to enroll in Medicare Part B effective the date of retirement. However, a member and his or her Medicare-eligible spouse can enroll in Medicare Part B only during certain times allowed by Medicare. Medicare-eligible members should enroll in Part A and Part B no later than the date of retirement of the policyholder.

The Social Security Administration handles Medicare enrollments. Therefore, if you have questions about when to enroll in Medicare Part B, you should contact the Social Security Administration at 800-772-1213. A Medicare-eligible retiree and/or spouse must have both Medicare Part A and Part B to have adequate coverage with PEEHIP. If you do not have Part B, PEEHIP will only pay 20% of the Medicare allowable fee (subject to a $20 copay on office visits, emergency room visits and outpatient consultations) as if you had Part B.

If I work after age 65 or become eligible for Medicare, am I still covered?

If you continue to be actively employed when you are age 65 or older and are insured on a PEEHIP active contract, you and your spouse will continue to be covered for the same benefits available to employees under age 65. In this case, your group benefits plan will pay all eligible expenses first. If you are enrolled in Medicare, Medicare will pay for Medicare-eligible expenses, if any, not paid by the group benefits plan.

If both you and your spouse are over age 65, you may elect to withdraw completely from the PEEHIP plan and purchase a Medicare Supplement contract. This means that you will have no benefits under the PEEHIP plan. In addition, the employer is prohibited by law from purchasing your Medicare Supplement contract for you or reimbursing you for any portion of the cost of the contract.

Other Medicare Rules

Disabled Individuals: If you or your spouse is eligible for Medicare due to disability and also covered under the plan by virtue of your current employment status with the employer, the plan will be primary and Medicare will be secondary.

End-Stage Renal Disease: If you are eligible for Medicare as a result of End-Stage Renal Disease (permanent kidney failure), the plan will generally be

primary and Medicare will be secondary for the first 30 months of your Medicare eligibility. Thereafter, Medicare will be primary and the plan will be secondary.

If you have any questions about coordination of your coverage with Medicare, please contact PEEHIP for further information.

PEEHIP members who retired on disability after September 30, 2005 but are also eligible for service retirement are subject to the Sliding Scale for PEEHIP premiums.

Medicare rules require a Medicare-eligible, active PEEHIP member who is covered on their spouse's PEEHIP **retired** contract to have Medicare as the primary payer on the active PEEHIP member. The active, Medicare-eligible member will need Medicare Part A and Part B coverage.

If the active member does not want Medicare as his or her primary payer and does not want to enroll in Medicare Part B until retirement, he or she will have to enroll in a PEEHIP **active** contract and will not be able to combine allocations with the retired PEEHIP-eligible spouse. Most of the time, in this situation, active members must wait and enroll in their own PEEHIP medical policy during the Open Enrollment period or their spouse's date of retirement. When the active Medicare-eligible member retires, he or she will need to enroll in Medicare Part B. The effective date of Medicare Part B needs to be the date of retirement to avoid a lapse in coverage.

Retired Employees

Retired employees are not affected by the TEFRA amendment to the Age Discrimination in Employment Act; therefore, upon retirement and Medicare eligibility the member's coverage under PEEHIP will complement his or her Medicare coverage. Medicare will be the primary payer and PEEHIP will be the secondary payer for retirees and dependents eligible for Medicare. Medicare approved admissions will not be subject to the Preadmission Certification requirements.

PEEHIP remains primary for retirees until the retiree is Medicare-eligible. A Medicare-eligible retiree and/or spouse must have both Medicare Part A and Part B to have adequate coverage with PEEHIP. Most Medicare-eligible retirees and dependents should not enroll in the Medicare Part D program.

After Medicare pays 80% of the approved amount after the Part B deductible, PEEHIP will pay the remainder of the Medicare approved amount without a Major Medical deductible (subject to a $20 copay on office visits, emergency room visits and outpatient consultations) on PEEHIP approved services. In rare situations some services are covered by Medicare and are not by PEEHIP. In the rare situation that a service is not covered by Medicare but is covered by PEEHIP, PEEHIP will be primary and all PEEHIP deductible and copayment amounts will apply as will all PEEHIP precertification requirements.

Health Insurance Policies for Retired Members

Form 10 Application for Retirement

In order to file for retirement benefits, a member must complete Part I, Retirement Application Packet. The law provides that an application for retirement must be filed with the Teachers' Retirement System Board of Control no less than thirty (30) days nor more than ninety (90) days before the first of the month in which retirement is to be effective.

The member must complete the PEEHIP Insurance Authorization section on the back of the Form 10 to authorize health insurance coverage. However, this section cannot be used as a PEEHIP enrollment form.

If a member is enrolled in the PEEHIP Hospital Medical Plan and one or more Optional Plans, he or she cannot drop the Optional Plan(s) until the Open Enrollment period.

The state allocation for retired members will pay the premium for two of the Optional Plans without a payroll deduction for those retired members enrolled in only the optional coverages. The member must indicate which coverages he or she wants to keep on his or her date of retirement.

A Member Retiring from a Non-Participating System

A member who retires from a non-participating system is eligible to add the PEEHIP Hospital Medical Plan on the date of retirement. If the member had a Hospital Medical Plan with his or her school system immediately prior to retirement, the member can enroll in PEEHIP with no waiting periods.

If the member did not have a Hospital Medical Plan with his or her school system, the member can enroll in single PEEHIP or the PEEHIP Supplemental Plan but will be required to serve a 270-day waiting period on pre-existing conditions unless proof of previous coverage is received and approved by PEEHIP.

If the retiring member only had single coverage, he or she cannot add family coverage on the date of retirement. In this situation, the retiring member must wait until the Open Enrollment period to add family coverage.

The retiring employee can only enroll in the PEEHIP Hospital Medical Plan or PEEHIP Supplemental Plan and not the Optional Plans on his or her date of retirement if the employee retires outside of the Open Enrollment period. The employee cannot add any Optional Plans until the Open Enrollment period.

The retiring employee may be eligible to begin combining insurance allocations with his or her spouse if both are independently eligible for PEEHIP. Members should contact PEEHIP for eligibility requirements. Generally, it is more cost effective for married couples who are both eligible for PEEHIP to combine insurance allocations and carry family Hospital Medical coverage instead of having two individual policies.

Vested Members Not Currently Enrolled

A retiring employee who has had a break in his or her employment and retires outside of the Open Enrollment period must serve a 270-day waiting period on pre-existing conditions unless proof of previous coverage is received and approved by PEEHIP.

A vested retiring employee can only enroll in the PEEHIP Hospital Medical Plan or PEEHIP Supplemental Plan and not the Optional Plans on his or her date of retirement.

A vested retiring employee can wait to enroll in the PEEHIP Hospital Medical Plan effective October 1. At this time, the vested employee will not be required to serve waiting periods and will be allowed to enroll in any of the Optional Plans.

The vested retiring employee may be eligible to begin combining insurance allocations with his or her spouse if both are independently eligible for PEEHIP. Members should contact PEEHIP for eligibility requirements. Generally, it is more cost effective for married couples who are both eligible for PEEHIP

to combine insurance allocations and carry family Hospital Medical coverage instead of having two individual policies.

A Member Retiring from a Participating System

If a member retires from a participating system and was enrolled in the four Optional Plans at his or her date of retirement, the member can continue coverage under all four Optional Plans or may reduce coverage to two plans on his or her date of retirement. The member cannot reduce to three Optional Plans outside of Open Enrollment.

If a member has the PEEHIP Hospital Medical Plan and one or more Optional Plans, he or she cannot drop the Optional Plan(s) until the Open Enrollment period. Also, a member cannot add any of the Optional Plans on the date of retirement. The state allocation will cover the full cost of two Optional Plans for retirees.

A member who is retiring from a participating system and is only enrolled in the Optional Plans at the date of retirement cannot add the Hospital Medical Plan until the Open Enrollment period.

Retiree Examples

Example 1:

Mr. Smith retired from Jefferson County school system on January 1. Mr. Smith was enrolled in the four Optional Plans on his date of retirement. Mr. Smith can drop two of the Optional Plans on January 1, or Mr. Smith can retain all four Optional Plans and pay $76.00 for the Optional Plans. Mr. Smith cannot add the PEEHIP Hospital Medical Plan nor is he allowed to drop only one Optional Plan until the Open Enrollment period.

Example 2:

Mrs. Scott retired from the University of Alabama (a non-participating system) on January 1. Mrs. Scott was enrolled in the Blue Cross and Blue Shield Health Insurance Plan with the University of Alabama. Therefore, Mrs. Scott can enroll in the PEEHIP plan on January 1, without waiting periods. If Mrs. Scott was enrolled in the family Blue Cross and Blue Shield plan with the University of Alabama, Mrs. Scott and her dependents would not be required to serve waiting periods on pre-existing conditions. However, if Mrs. Scott only had the single Blue Cross plan, Mrs. Scott could not enroll her family in the PEEHIP plan until the Open Enrollment period.

Example 3:

Mr. Johnson was employed with Birmingham City and retired on March 1. Mr. Johnson was enrolled in the family Dental and family Hospital Medical Plan with Birmingham City. On his date of retirement, Mr. Johnson would be required to continue his Dental Plan until the Open Enrollment period. Mr. Johnson could drop his PEEHIP Hospital Medical Plan on his date of retirement or at any other time by notifying PEEHIP in writing and the change would be effective the first day of the month following the notification.

Example 4:

When Mrs. Sellers was age 55, she terminated her employment with Auburn University with 11 years of service. When she turned age 60, she began drawing a retirement check and became eligible for the PEEHIP Hospital Medical Plan. Mrs. Sellers is eligible to enroll in the PEEHIP Hospital Medical Plan or PEEHIP Supplemental Plan effective the date of her retirement or she could wait until the Open Enrollment period. She would be required to serve a 270-day waiting period on pre-existing conditions if she retired outside of the Open Enrollment period and enrolled in PEEHIP on her date of retirement unless proof of previous coverage was received and approved by PEEHIP. She could wait and enroll in PEEHIP during the Open Enrollment period and would not be required to serve the 270-day waiting period on pre-existing conditions.

A Medicare-Eligible Retiree

If a member or dependent is Medicare-eligible due to age or disability at the time of his or her retirement, Medicare will become the primary payer and PEEHIP the secondary payer effective on the date of the member's retirement. The PEEHIP Hospital Medical Plan will supplement the Medicare coverage.

It is extremely important for the Medicare-eligible member and/or dependent to have Medicare Part A

and Part B to assure adequate coverage with PEEHIP. In addition, the member should notify Medicare of his or her retirement date and request Medicare to change their records to reflect that Medicare should be the primary payer and PEEHIP the secondary payer effective on the date of the member's retirement. Most Medicare-eligible retirees and dependents should not enroll in the Medicare Part D program if they are enrolled in the PEEHIP Medicare Plus program.

If the member or dependent is under age 65 and Medicare-eligible due to a disability, the member is eligible for a reduced premium rate for PEEHIP. The PEEHIP office must receive a copy of the member or dependent's Medicare card before the premium rate can be reduced. However, PEEHIP will pay secondary to Medicare once our office becomes aware of your Medicare eligibility regardless of whether our office has received your Medicare card. Medicare-eligible members and dependents should have Medicare Part A **and** Part B to have adequate coverage.

A Retired Member with a Medicare-Eligible Dependent

If the retired member is carrying family coverage and has a Medicare-eligible dependent, Medicare will become the primary payer for the dependent and PEEHIP will be the secondary payer at the time of retirement. The member must notify Medicare and PEEHIP. The dependent needs Medicare Part A and Part B effective on the date of the member's retirement. Most Medicare-eligible dependents should not enroll in the Medicare Part D program.

A Retired Member With Student Dependents

PEEHIP will send a student verification letter to the member a few months before a student dependent's birthday. The member must then confirm the dependent's eligibility or non-eligibility as a student by calling the automated response line at 877-517-0020 and giving PEEHIP the necessary information. PEEHIP records the information and updates its records. If PEEHIP is given incorrect information, the member is responsible for all claims incurred on the student. Members also have the option of updating their student dependent through Member Online Services by going to the RSA Web site at www.rsa-al.gov.

If a student dependent's status is not updated in a timely manner, the student dependent is cancelled and PEEHIP requires written verification from the registrar's office to get the student reinstated. If the student dependent's status changes during the year, the member is responsible for notifying PEEHIP.

Medicare Part D Prescription Drug Benefit Resources

Telephone Number	Description
Medicare 800-MEDICARE 800-633-4227	Medicare Help Line
Social Security Administration 800-772-1213	Recorded information and services are available 24 hours a day, including weekends and holidays.

Web Site	Description
Medicare www.medicare.gov	Provides access to information about Medicare and Medicare health plans.
Centers for Medicare and Medicaid Services www.cms.hhs.gov	CMS administers Medicare and Medicaid programs. A database of frequently asked questions is available.
Social Security Administration www.ssa.gov	Link to the Social Security Administration's site for information on low-income subsidies and other resources.
AARP www.aarp.com/bulletin	Access the Medicare Benefit Drug Calculator, which illustrates what the Medicare drug benefit means to you.
Access to Benefits Coalition www.accesstobenefits.com	Prescription drug savings for those who need them most.
Aging Parents and Elder Care www.todaysseniors.com	Senior Solutions is an independent organization providing information on issues to help seniors get the most out of retirement.

Web Site	Description
Benefits Check Up https://ssl.benefitscheckup.org	A service of the National Council on the Aging; helps find programs for people ages 55 and over that may pay some costs of prescription drugs, health care, utilities, and other essential items or services.
Destination Rx www.destinationrx.com	Provides a pharmacy discount buying service.
Medicare Rights Center www.medicarerights.org	Medicare Rights Center (MRC) is the largest independent U.S. source of health information and assistance for people with Medicare.
Needymeds.com www.needymeds.com	Find information on patient assistance programs that provide no cost prescription medications to eligible participants.
Rxaminer.com www.rxaminer.com	Use this prescription drug comparison tool to find lower-cost prescription drugs.
Together Rx www.togetherrx.com	Offers a prescription drug savings program.

Creditable Coverage Notice About Your Prescription Drug Coverage and Medicare

This information is about your current prescription drug coverage with PEEHIP and prescription drug coverage under Part D of Medicare for people with Medicare. It also explains where to find more information to help you make decisions about your prescription drug coverage.

- PEEHIP has elected to continue providing prescription drug benefits even when members are eligible for Medicare Part D benefits. However, members cannot enroll in Medicare Part D and continue with PEEHIP prescription drug coverage.

- The prescription drug coverage offered by PEEHIP is expected to pay out as much as the standard Medicare prescription drug coverage and, therefore, the PEEHIP prescription drug coverage is considered "creditable coverage" as defined by Medicare.

- "Low-income" individuals may be eligible for prescription drug subsidies. Therefore, these individuals may be better off applying for a subsidy and Medicare Part D (two separate steps).

- Individuals dropping or losing their PEEHIP coverage must enroll in Medicare Part D within 60 days or they will be subject to a higher premium.

If you do decide to enroll in a Medicare prescription drug plan and drop your PEEHIP prescription drug coverage, be aware that you will lose your PEEHIP drug coverage and will not be able to get this coverage back until you drop the Medicare Part D coverage. Keep in mind that you will not be able to take advantage of coverage under both the PEEHIP prescription drug program and through Medicare Part D.

Because the PEEHIP prescription drug coverage is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later without a late enrollment penalty. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15 and December 31.

Compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. In most cases, PEEHIP will continue to be your best choice to maximize your benefits.

An exception may apply to certain "low-income" individuals who may be eligible for prescription drug subsidies, and thus may be better off applying for a subsidy and Part D (two separate steps). Individuals who have incomes below 150 percent of the Federal Poverty Level and assets of not more than $10,000 per individual or $20,000 per couple (not including homes, cars, household furnishings and possessions) may be eligible for the prescription drug subsidies. The Social Security Administration (SSA) has developed an application form and process to determine eligibility. If you feel you may qualify, go to the SSA Web page at www.socialsecurity.gov and click Medicare Prescription Drug Plan. Also, you may call or visit your local SSA office for more details; the national toll-free number is 800-772-1213.

PEEHIP members who drop or lose their coverage with PEEHIP and do not enroll in Medicare prescription drug coverage after their current coverage ends, may pay more to enroll in Medicare Part D later. Individuals having a 60 day or longer break in prescription drug coverage that is at least as good as Medicare's prescription drug coverage will be subject to at least 1% per month premium increase for every month after May 15, 2006, that they did not have prescription drug coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. This higher premium will continue as long as you have Medicare coverage. In addition, you may have to wait until the next November to enroll.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), requires PEEHIP and most other group health plans to offer employees and their families the opportunity for a temporary extension of health coverage. The continuation of coverage is offered at group rates in certain instances where coverage under PEEHIP would otherwise end.

All public education employees of the state of Alabama who are covered under the PEEHIP group health insurance have the right to choose continuation of coverage if the employee loses group health coverage due to a reduction in hours of employment or because of a resignation or termination of employment (for reasons other than gross misconduct on the part of the employee).

Each public education institution has the responsibility by law to notify the PEEHIP office immediately when an employee loses group health coverage due to the employee's:

- death,
- termination of employment, or
- reduction in hours.

COBRA Compliance and PEEHIP Notification

The sanctions imposed under the auspices of COBRA can be quite severe, making a determination of compliance greatly important. It is the employer's responsibility to notify PEEHIP within a maximum of 30 days of an employee's termination, death or reduction in hours. The employer must notify the PEEHIP office by entering a termination date in the employer portal before the next payroll cycle. Employers must key the termination date in the employer portal for each employee who loses insurance coverage due to termination or resignation of employment or reduction in hours or for an employee who does not earn the state allocation, even if the employee does not want to continue the coverage or is transferring allocation to a spouse.

It is the employee's or dependent's responsibility to notify PEEHIP within a maximum of 60 days when the **dependent** needs continuation coverage under COBRA.

Termination for Gross Misconduct

If an employer terminates an employee for gross misconduct, PEEHIP is not required to provide continuation of coverage under the provisions of COBRA. However, the employer must still notify the PEEHIP office of the termination by entering the termination information via the employer portal.

Eligibility

Under COBRA, the employee, ex-spouse or dependent family member has the responsibility to inform PEEHIP within 60 days of a divorce, legal separation, or a child losing dependent status under the Plan and must obtain a Continuation of Coverage Application form. PEEHIP may be notified by phone or in writing.

A dependent's coverage ends on the last day of the month in which the dependent becomes ineligible by turning age 19 or 25, if a full-time student, or by marriage, divorce, or legal separation.

When PEEHIP is notified of a qualifying event, PEEHIP will in turn notify the eligible member that he or she has the right to choose continuation of coverage. It is important to note that the eligible member has 60 days from the date he or she would lose coverage because of one of the qualifying events to inform PEEHIP that he or she wants continuation of coverage.

If the eligible member does not choose continuation of coverage, his or her PEEHIP group health insurance coverage will end the last day of the month in which the member becomes ineligible.

If a member and/or dependent become entitled to Medicare after electing COBRA coverage, he or she is no longer eligible to continue the COBRA coverage. However, dependents on the contract will be allowed to continue COBRA coverage up to a total of 36 months from the date of the original qualifying event.

Continuation of Coverage

If the eligible member chooses continuation of coverage, PEEHIP is required to give the member coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members and is the same coverage he or she had prior to the qualifying event.

COBRA requires that the eligible member be afforded the opportunity to maintain continuation of coverage for 18 months due to a termination of employment or reduction in hours. COBRA requires that eligible dependents who become eligible for COBRA for reasons such as aging out, no longer a student, or divorce be afforded an opportunity to maintain coverage for 36 months.

COBRA members have the same rights such as adding a newborn child or a new spouse within 45 days of the date of birth or marriage as other employed or retired members.

COBRA also provides that a member's continuation of coverage may be cut short for any of the following five reasons:

1. PEEHIP no longer provides group health coverage to any of its employees.
2. The premium for continuation of coverage is not paid by the member when payment is due, or the premium payment is insufficient.
3. The member becomes covered under another group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition.
4. The member or dependent becomes entitled to Medicare after COBRA benefits begin.
5. The member becomes divorced from a covered employee and subsequently remarries and is covered under the new spouse's group health plan, which does not contain any exclusions or limitations with respect to pre-existing conditions.

An eligible member does not have to show that he or she is insurable to choose continuation of coverage. However, under COBRA, he or she is required to pay the full COBRA monthly premium for continuation of coverage.

If a member who is on COBRA dies before the 18 months have lapsed and the member's family is covered under COBRA, the eligible covered family members can continue the COBRA coverage up to a total of 36 months from the date of the original qualifying event.

Dependent Coverage

A spouse of an employee covered by PEEHIP has the right to choose continuation of coverage if the spouse loses group health coverage under the Plan for any of the following reasons:

- death of the employee
- termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment
- divorce or legal separation
- employee's eligibility for Medicare

In the case of a dependent child of an employee covered by PEEHIP, he or she has the right to continuation of coverage if group health coverage under the Plan is lost for any of the following reasons:

- death of a parent
- termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the employer
- parents' divorce or legal separation
- parent becomes eligible for Medicare
- dependent ceases to be a dependent child under the Plan

Members on COBRA Who Return to Work

When a member who is enrolled in PEEHIP under COBRA returns to work and does not have a break in coverage, the member is not allowed to change coverage until the Open Enrollment period.

If a member chooses not to continue their insurance coverage under COBRA and has a break in coverage, the member must complete a new enrollment application when he or she is re-employed in public education.

Exception: Employees enrolled in one or more Optional Plans while on COBRA can add the remaining Optional Plans when he or she becomes eligible for a full allocation. However, employees enrolled in one or more Optional Plans while on COBRA cannot enroll in a Hospital Medical Plan until Open Enrollment.

Can COBRA Coverage be Extended for Covered Members who Become Disabled?

Yes. In certain circumstances, COBRA can be extended for covered members who become disabled. If a covered member becomes disabled under Title 11 (OASDI) or Title XVI (SSI) of the Social Security Act during the first 60 days after the employee's termination of employment or reduction in hours, the 18-month period may be extended to 29 months on the date the disabled individual becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverages, regardless of whether the disabled individual elects the 29-month period for him or herself.

In order for this disability extension to apply, you must notify the PEEHIP office of Social Security's determination within 60 days after the date of the determination and before the expiration of the 18-month period. You must also notify PEEHIP within 30 days of any revocation of Social Security disability benefits.

The cost for COBRA coverage after the 18th month will be 150% of the full COBRA cost of coverage under the plan, assuming that the disabled individual elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

For spouses and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. The 36-month period will run from the original date of the termination of employment or reduction in hours.

Leave of Absence

A member who goes on an authorized leave of absence without pay can continue group health coverage for up to two years of authorized leave before he or she would be required to enroll in continuation of coverage under the COBRA provisions. A member on an approved leave of absence can continue the health insurance coverage for two years and then can continue the health insurance coverage for an additional 18 months under the COBRA provisions.

Leave of Absence & Family and Medical Leave Act

Leave of Absence

The beginning date of the leave of absence should be the date any accrued leave is exhausted (sick leave, donated leave, annual leave or personal days).

The employer must enter the leave of absence status and beginning date in the Employer Portal when an employee is granted an official leave of absence. Upon return to work, employees who paid for their insurance while on an authorized leave of absence cannot pick up new insurance coverage that they did not have while on leave. (See *Exception*)

Employees who do not pay for their insurance while on an official leave of absence or have a break in coverage can enroll as new employees the day they return to work, the first day of the month after they return to work, or October 1. PEEHIP must receive a new Health Insurance and Optional Enrollment Application before the member can be enrolled. The employee and his eligible dependents will be required to serve a 270-day waiting period on all pre-existing conditions with the Hospital Medical coverage if proof of previous coverage is not received and approved by PEEHIP.

Employees who continue insurance coverage while on leave must wait until the Open Enrollment period to make insurance changes for an October 1 effective date.

Exception: Employees enrolled in one or more Optional Plans while on leave of absence can add the remaining Optional Plans when he or she becomes eligible for a full allocation. However, employees enrolled in one or more Optional Plans while on leave cannot enroll in a Hospital Medical Plan until Open Enrollment.

When the employee returns to work, the employer must update the Employer Portal and enter the hire status as the date the leave of absence terminated.

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 requires employers to continue health benefits to employees taking FMLA Leave.

Eligibility

Employees are eligible for leave under FMLA if they have worked 1,250 hours over the prior 12 months and if they have worked for a covered employer for at least one year. (Although bus drivers are classified as full-time, normally they do not work 1,250 hours.)

Conditions

- Leave earned under FMLA is for a maximum of 12 weeks not 3 months.
- Employees must provide a 30-day notice for foreseeable leave. Leave under FMLA cannot be granted retroactively.
- Leave granted under FMLA cannot and should not be applied to the summer months for 9-month employees or during any time that the employee is not required to be at work. FMLA should begin when member is required to be at work.
- If an employee earns an extra summer allocation under the 3-1 Rule, that month should be applied to the end of the 12 weeks that were granted under FMLA.
- An employee cannot earn the insurance allocation under FMLA if he or she is retiring or not returning to work unless the reason for not returning to work is a serious health condition or circumstance beyond the control of the employee.
- The school system will collect premiums while the employee is on leave under FMLA and should collect premiums for any extra months earned under the 3-1 Rule.
- Employers must enter the FMLA status and beginning date in the Employer Portal when an employee is granted FMLA.
- Employees on FMLA do accrue extra insurance allocation while on leave under FMLA. Therefore, the 3-1 Rule does apply while an employee is on FMLA.
- Employers must enter the new status and ending date in the Employer Portal when the FMLA benefit ends.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects Americans who move from one job to another, who are self-employed, or who have pre-existing medical conditions. HIPAA applies to the PEEHIP Hospital Medical Plan and the HMO plan. HIPAA does not apply to the four Optional Plans administered by Southland National Insurance Corporation.

HIPAA provides for increased health coverage portability for our members with fewer restrictions on pre-existing conditions, certification requirements for prior health coverage, and special enrollment periods. HIPAA provides for other benefits such as guaranteed availability and renewability of health insurance coverage.

HIPAA includes the following:

- requires plans to give credit toward a member's or dependent's pre-existing condition limitations period for prior creditable coverage
- defines what can be a pre-existing condition
- requires plans, on an individual's request, to certify the period of previous insurance coverage
- limits the period during which pre-existing condition limitations can be imposed
- prohibits the use of pre-existing condition limitations for pregnancies, adopted children and newborns

Credit Must Be Given for Creditable Coverage

When medical coverage is cancelled on a PEEHIP member or dependent, Blue Cross and Blue Shield of Alabama or VIVA Health Plan HMO will mail the Certificate of Creditable Coverage to the member's address on file. This certificate provides evidence of prior health coverage and can be used to demonstrate creditable coverage to the member's new plan or issuer. The certificate can be furnished automatically to members and upon request by an individual within 24 months after coverage ends.

PEEHIP and the HMO plan will accept the Certificates of Creditable Coverage from other plans for members enrolling in PEEHIP outside of the Open Enrollment period and will reduce their pre-existing condition exclusion period by the length of the total period of prior creditable coverage. If there is a break in coverage longer than 63 days, PEEHIP and the HMO Plan are not required to accept the Certificate of Creditable Coverage. Members must send the certificate to PEEHIP to receive credit for previous coverage.

Special Enrollment Periods

HIPAA requires group health plans to provide special enrollment periods during which certain individuals who previously declined health coverage are allowed to enroll. A special enrollee is not treated as a late enrollee. The 9-month pre-existing condition waiting period may be applied to a special enrollee but must be reduced by the special enrollee's creditable coverage. Special enrollment occurs when:

- an individual with other insurance coverage loses that coverage
- a person becomes a dependent through marriage
- a birth of a dependent child
- an adoption or placement of adoption of a child under the age of 18

These individuals are not required to wait until the Open Enrollment period to enroll. This special enrollment period is available to employees and their dependents who meet certain requirements:

1. The employee or dependent must otherwise be eligible for coverage under the terms of their plan.
2. When the PEEHIP coverage was previously declined, the employee or dependent must have been covered under another group health plan or must have had other health insurance coverage.
3. If the other coverage is COBRA continuation of coverage, the special enrollment can only be requested after exhausting COBRA continuation of coverage.
4. If the other coverage is not COBRA continuation of coverage, special enrollment can only be requested after losing eligibility

for the other coverage or after cessation of employer contributions for the other coverage. In each case, the employee has 45 days to request special enrollment.

An individual does not have a special enrollment right if the individual loses the other coverage for the following reasons:

1. as a result of the individual's failure to pay premiums
2. for cause (such as making a fraudulent claim)
3. if other coverage has an increase in premiums or a change in benefits

These examples do not qualify as a loss of coverage under the HIPAA Federal guidelines.

The special enrollment for new dependents can occur if a person has a new dependent by birth, marriage, adoption, or placement for adoption. The election to enroll must be made within 45 days following the birth, marriage, adoption, or placement for adoption.

If the request is not made within 45 days of the loss of coverage, the special enrollment benefit does not apply. In addition, the coverage effective date must be within 45 days of the loss of coverage.

Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

The Public Education Employees' Health Insurance Plan (the "Plan") considers personal information to be confidential. The Plan protects the privacy of that information in accordance with applicable privacy laws, as well as its own privacy policies.

The Plan is required by law to take reasonable steps to ensure the privacy of your health information and to inform you about:

- the Plan's uses and disclosures of your health information
- your privacy rights with respect to your health information
- the Plan's obligations with respect to your health information
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services
- the person or office to contact for further information about the Plan's privacy practices

Effective Date of Notice: This notice was effective as of April 14, 2003.

How the Plan Uses and Discloses Health Information

This section of the notice describes uses and disclosures that the Plan may make of your health information for certain purposes without first obtaining your permission as well as instances in which we may request your written permission to use or disclose your health information. The Plan also requires their business associates to protect the privacy of your health information through written agreements.

Uses and disclosures related to payment, health care operations and treatment

The Plan and its business associates may use your health information without your permission to carry out payment or health care operations. The Plan may also disclose health information to the Plan Sponsor, PEEHIP, for purposes related to payment or health care operations.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, review for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell an insurer what percentage of a bill will be paid by the Plan.

Health care operations include but are not limited to underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts, disease management, case management, conducting or arrangement for medical review, legal services and auditing functions, including fraud and abuse programs, business planning and development, business management and general administrative activities. It also includes quality assessment and improvement and reviewing competence or qualifications of health care professionals. For

example, the Plan may use medical benefit claims information to conduct a review of the accuracy of how benefit claims are being paid.

Other uses and disclosures that do not require your written authorization

The Plan may disclose your health information to persons and entities that provide services to the Plan and assure the Plan they will protect the information or if it:

- Constitutes summary health information and is used only for modifying, amending or terminating a group health plan or obtaining premium bids from health plans providing coverage under the group health plan
- Constitutes de-identified information
- Relates to workers' compensation programs
- Is for judicial and administrative proceedings
- Is about decedents
- Is for law enforcement purposes
- Is for public health activities
- Is for health oversight activities
- Is about victims of abuse, neglect or domestic violence
- Is for cadaveric organ, eye or tissue donation purposes
- Is for certain limited research purposes
- Is to avert a serious threat to health or safety
- Is for specialized government functions
- Is for limited marketing activities

Additional disclosures to others without your written authorization

The Plan may disclose your health information to a relative, a friend or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, the Plan may confirm whether or not a claim has been received and paid. You have the right to request that this kind of disclosure be limited or stopped by contacting the Plan's Privacy Official.

Uses and Disclosures Requiring Your Written Authorization

In all situations other than those described above, the Plan will ask for your written authorization before using or disclosing your health information. If you have given the Plan an authorization, you may revoke it at any time, if the Plan has not already acted on it. If you have questions regarding authorizations, contact the Plan's Privacy Official.

Your Privacy Rights

This section of the notice describes your rights with respect to your health information and a brief description of how you may exercise these rights. To exercise your rights, you must contact the Plan's Privacy Official at 877-517-0020.

Restrict Uses and Disclosures

You have the right to request that the Plan restricts uses and disclosure of your health information for activities related to payment, health care operations and treatment. The Plan will consider, but may not agree to, such requests.

Alternative Communication

The Plan will accommodate reasonable requests to communicate with you at a certain location or in a certain way. For example, if you are covered as an adult dependent, you may want the Plan to send health information to a different address than that of the Employee.

Copy of Health Information

You have a right to obtain a copy of health information that is contained in a "designated record set" – records used in making enrollment, payment, claims adjudication, and other decisions. The Plan may provide you with a summary of the health information if you agree in advance to the summary. You may also be asked to pay a fee of $1.00 per page based on the Plan's copying, mailing, and other preparation costs.

Amend Health Information

You have the right to request an amendment to health information that is in a "designated record set." The Plan may deny your request to amend your health information if the Plan did not create the health information, if the information is not part of the Plan's records, if the information was not available for inspection, or the information is not accurate and complete.

List of Certain Disclosures

You have the right to receive a list of certain disclosures of your health information. The Plan or its business associates will provide you with one free accounting each year. For subsequent requests, you may be charged a reasonable fee.

Right to A Copy of Privacy Notice

You have the right to receive a paper copy of this notice upon request, even if you agreed to receive the notice electronically.

Complaints

You may complain to the Plan or the Secretary of HHS if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

The Plan's Responsibilities

The Plan is required by a federal law to keep your health information private, to give you notice of the Plan's legal duties and privacy practices, and to follow the terms of the notice currently in effect.

This Notice is Subject to Change

The terms of this notice and the Plan's privacy policies may be changed at any time. If changes are made, the new terms and policies will then apply to all health information maintained by the Plan. If any material changes are made, the Plan will distribute a new notice to participants and beneficiaries.

Your Questions and Comments

If you have questions regarding this notice, please contact the Plan's Privacy Official at 877-517-0020.

Notice to Enrollees in a Self-Funded Non-Federal Governmental Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Public Education Employees' Health Insurance Board has elected to exempt the **Public Education Employees' Health Insurance Program** from the following requirement:

> Prohibitions against discriminating against individual participants and beneficiaries based on health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

The exemption from this federal requirement has been in effect since October 1, 2005. The election has been renewed every subsequent plan year.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a pre-existing condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

For more information regarding this notice, please contact PEEHIP.

Forms

Mail forms to: Public Education Employees' Health Insurance Plan
P.O. Box 302150
Montgomery, AL 36130-2150

A self-addressed envelope is included in this packet to return forms to PEEHIP. Do not send any forms to Blue Cross Blue Shield, VIVA, or Southland National. When completing these forms, make sure the name of the subscriber and dependents is the same as the name on their Social Security card. Forms can also be downloaded from our Web site at **www.rsa-al.gov**.

Health Insurance and Optional Enrollment Application – This form is to be used if you are: a **new** employee; an active or retired member who is **not** enrolled in any coverage; or an active or retired member who wants to **enroll** in one or more Optional Coverage Plans that you are not enrolled in, or are not enrolled in a Hospital Medical Plan and want to enroll. Any **changes** to existing coverages are to be made on the Health Insurance and Optional Status Change form.

Health Insurance and Optional Status Change – This form is to be used if you are an active or retired member currently enrolled in PEEHIP and you want to make changes to your existing coverage, and/or to certify or change your or your spouse's tobacco status. Examples: change from single to family coverage or vice-versa; cancel coverage; change your Hospital Medical Plan; add or cancel a dependent to or from family coverage. **Important:** You must provide the Requested Effective Date or the form will be returned to you for completion.

Flexible Spending Account Enrollment Application – This form is to be used if you are an **active** member and you wish to enroll or re-enroll in the Health Care and/or Dependent Care Flexible Spending Accounts. **Important:** You must re-enroll in these programs **every year** as these programs will **not** automatically renew each year without a new enrollment application. The **Health Care Account** allows members to pay for non-covered health care expenses with pre-tax dollars. The **Dependent Care Account** allows members to pay for dependent care expenses with pre-tax dollars.

Flexible Spending Account Status Change – This form is to be used if you are an **active** member and you enrolled or re-enrolled in a Flexible Spending Account(s) during Open Enrollment and subsequently wish to make a **change** to the annual contribution amount of your Flexible Spending Account(s) **before** the end of Open Enrollment or during the year if you have a qualifying life event.

Federal Poverty Level Assistance (FPL) Application and Children's Health Insurance Plan (CHIP) Application – This form is to be used by eligible active and retired members to apply for the FPL premium discount and/or to enroll or re-enroll in the PEEHIP CHIP plan. **Members must re-enroll in these programs every year.** These programs will not automatically renew each year without a new application.

Important for New Employees
The Health Insurance and Optional Enrollment Application must be completed within 30 days of the member's employment date.

Online Forms

PEEHIP has a new and improved Member Online Services system that is fast, free, secure and accurate! Click on the **Member Online Services** link from the RSA Web site at www.rsa-al.gov to access the new online system. All you need is a User ID and Password. If you don't already have these, registering for an account is easy! The link above will guide you through the necessary steps to set up your account to obtain a User ID and Password.

PEEHIP Members Can Do The Following Online: *(Some of the options are only available during the annual Open Enrollment period.)*

- View Current Coverages
- View and/or Update your Contact Information
- Enroll, Change or Cancel your Hospital Medical Plan
- Enroll, Change or Cancel your Optional Coverage Plans (Cancer, Dental, Indemnity & Vision)
- Add, Update or Cancel your Other (non-PEEHIP) Group Insurance Coverage Information
- Enroll or Re-enroll in Flexible Spending Accounts
- Add or Update your Medicare Information
- Add or Update Retiree Employer Information
- Update your Student Dependent Status
- Update your and/or your Spouse's Tobacco Usage Status
- Add Dependent(s) to Coverage
- Cancel Dependent(s) from Coverage

PEEHIP Enroll
(09/08)
0J

HEALTH INSURANCE AND OPTIONAL ENROLLMENT APPLICATION

Check One:
☐ Active Member
☐ Retired Member

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

This form is to be used to enroll in new coverages.
Any other changes are to be made on the Health Insurance and Optional Status Change Form.
In lieu of completing and mailing this form, you can make your changes online using the Web site above.
Please print and complete the front and back of form.

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Name/Initial	Last Name
____-____-____			

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone	Sex
____/____/____	____-____-____	____-____-____	☐ Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Employer/School System	Date of Employment
	____/____/____

Have you or your spouse used tobacco products within the last 12 months?* Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

This information is required for enrollment.

PEEHIP Coverage Information

For an effective date of coverage other than October 1, there is a 270 day waiting period for pre-existing conditions unless proof of previous coverage is received and approved by the PEEHIP office.

Basic Hospital/Medical (*Select only one of the three plans*)	**Optional Coverage(s)** (*administered by Southland National*)
Note: *PEEHIP plans are administered by Blue Cross and Blue Shield of AL* Coverage Type: ☐ PEEHIP Hospital/Medical ☐ PEEHIP Hosp/Med Supplemental**(*see Group Health on back*) *This plan is not a Medicare supplement & differs from Optional Plans.* ☐ VIVA Health Plan (HMO) ☐ Single or ☐ Family	***Note:*** *Optional plans must be all Single or all Family* Coverage Type(s): ☐ Cancer ☐ Dental ☐ Indemnity ☐ Vision ☐ Single or ☐ Family
Requested Effective Date ____/____/____ ***(required)***	**Requested Effective Date** ____/____/____ ***(required)***
Primary Care Physician *(HMO only)*	***Optional coverage(s) must be retained for one year until the following October 1. The PEEHIP office will not automatically cancel any coverage(s). All cancellations must be indicated on the Health Insurance Status Change form.***

Dependent Information *(only required for family coverage)*

Note: *Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card.*
Enrollments cannot be processed without the appropriate documentation as explained in the Member Handbook for any starred (*) items.

Name of Dependent *(First, MI, Last)*	**Social Security Number**	**Date of Birth**	**Relationship to Subscriber**	**Sex**	
			☐ Husband ☐ Wife ☐ Common-Law*	☐ M ☐ F	___/___/___ Marriage Date
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ____	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ____	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ____	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ____	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ____	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*

Student Verification *(only necessary to complete for dependent children **between the ages of 19 and 25**)*

If full-time student, list dependent's first name and university, college, or accredited vocational school.

Name	School	Term Attending	Hours Enrolled
Name	School	Term Attending	Hours Enrolled

Combining of Allocations

Allocations can only be combined at certain times and only if your spouse is independently eligible for PEEHIP.

I wish to ☐ transfer ☐ receive the state insurance allocation ☐ to ☐ from my spouse.

Spouse's Social Security Number: _____-_____-_____ Effective Date of Combining Allocations: _____/_____/_____

Additional (Non-PEEHIP) Group Health Insurance Coverage Information**

This section must be completed if the member elects the PEEHIP Supplemental Plan **or** if the member or dependent(s) have other group health, dental, or vision coverage currently in effect.

Name of Insurance Company	Policy Number
Name of Policy Holder	Relationship to Policy Holder

Policy Effective Date	Type of Coverage
_____/_____/_____	☐ Single ☐ Family

Medicare Information

This section must be completed if you or your dependents are eligible for Medicare.

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:_____/_____/_____ ☐ Part B-Effective:_____/_____/_____ ☐ Part D*-Effective:_____/_____/_____

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:_____/_____/_____ ☐ Part B-Effective:_____/_____/_____ ☐ Part D*-Effective:_____/_____/_____

**If you are enrolled in Medicare Part D, you are not eligible for the PEEHIP prescription drug plan coverage.*

Retiree Other Employer Information

The following fields must be completed by PEEHIP members who retire after September 30, 2005.

Pursuant to Act 2004-649, if you retire after September 30, 2005, and become employed by another employer and the other employer provides at least 50% of the cost of single health insurance coverage, you are required to use the other employer's health benefit plan for primary coverage. You may enroll in the PEEHIP Supplemental Plan or the PEEHIP Optional Plans.

Are you employed? ☐ Yes ☐ No If yes, please complete the employer information below.

Employer	Date of Employment	Last Day Employed
	_____/_____/_____	_____/_____/_____

Mailing Address	City	State	ZIP Code

Are you eligible for health insurance with your employer? ☐ Yes ☐ No

If yes, will your employer pay at least 50% of the cost of single health insurance coverage? ☐ Yes ☐ No

Name of Insurance Company	Policy Effective Date	Type of Coverage
	_____/_____/_____	☐ Single ☐ Family

PEEHIP Subscriber Certification

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan's behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse's tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Employee Signature _____ Date Signed _____/_____/_____

Please mail the completed form to the address located on the front of this form.

PEEHIP Change (09/08)
50

HEALTH INSURANCE AND OPTIONAL STATUS CHANGE

Check One:
☐ Active Member
☐ Retired Member

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

PEEHIP

This form is to be used to make changes to your existing insurance coverages and to certify or change your tobacco status.
In lieu of completing and mailing this form, you can make your changes online using the Web site above.
Please print and complete the front and back of form.

PEEHIP Subscriber Information

Name must be entered as shown on Social Security card. ***All address changes must be made on the Retirement Systems of Alabama Address Change forms.***

Social Security Number	First Name	Middle Name/Initial	Last Name
____-____-____			

Date of Birth	Daytime Phone	Marital Status
____/____/____	____-____-____	☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Have you or your spouse used tobacco products within the last 12 months?*
Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

This information is required for enrollment.

Please complete the following fields if you have changed your name or changed employers.

Previous Full Name *(First, MI, Last)* / Previous School System	New Full Name *(First, MI, Last)* / New School System	Date of Employment Transfer
		____/____/____

PEEHIP Coverage Information

For an effective date of coverage other than October 1, there is a 270 day waiting period for pre-existing conditions unless proof of previous coverage is received and approved by the PEEHIP office. The PEEHIP office will not automatically cancel any coverage(s). ***All cancellations must be indicated on the Health Insurance Status Change form.***

(Optional plans must be all Single or all Family)

Coverage Type: (Only check boxes requiring a change)	PEEHIP Hosp/Med	PEEHIP Supplemental	VIVA HMO	Cancer	Dental	Indemnity	Vision
Change from Single to **Family** Coverage	☐	☐	☐	☐	☐	☐	☐
Add dependent(s) listed below to Family Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel Coverage	☐	☐	☐	☐	☐	☐	☐
Change from Family to **Single** Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel dependent(s) listed below from Family Coverage	☐	☐	☐	☐	☐	☐	☐

Requested Effective Date ____/____/____ *(Date must be included or form will be returned)*
Note: You will be billed for prorata premiums or for premiums that are not deducted.

Reason for Status Change(s)

Changes cannot be processed without the appropriate documentation as explained in the member handbook for starred (*) items. ***Active members must have an IRS qualifying event to cancel their hospital medical or change their coverage outside of Open Enrollment because their premiums are pre-taxed.***

- ☐ Adoption of a child* *(need adoption papers)*
- ☐ Birth of a child* *(need birth certificate)*
- ☐ Death of spouse/dependent* *(need death certificate)*
- ☐ Dependent age 19 or older changing student status*
- ☐ Dependent loss of coverage* *(need proof of loss of coverage)*
- ☐ Divorce/Annulment* *(need divorce decree)*
- ☐ Legal custody of a child* *(need custody papers)*
- ☐ Marriage* *(need marriage certificate)*
- ☐ Marriage of dependent child
- ☐ Open Enrollment
- ☐ Termination of spouse/dependent employment*
- ☐ Commencement of spouse/dependent employment*
- ☐ Medicare/Medicaid entitlement* *(need copy of card)*

Date change occurred ***(Required)*** ____/____/____

Dependent Information *(only required for family coverage)*

Note: *Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card.*
Enrollments cannot be processed without the appropriate documentation as explained in the Member Handbook for any starred (*) items.

Name of Dependent *(First, MI, Last)*	Social Security Number	Date of Birth	Relationship to Subscriber	Sex	
			☐ Husband ☐ Wife ☐ Common-Law*	☐ M ☐ F	____/____/____ Marriage Date
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ________	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ________	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ________	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* ________	☐ M ☐ F	☐ Student* *(must complete other side)* ☐ Handicapped*

Student Verification *(only necessary to complete for dependent children **between the ages of 19 and 25**)*

If full-time student, list dependent's first name and university, college, or accredited vocational school.

Name	School	Term Attending	Hours Enrolled
Name	School	Term Attending	Hours Enrolled

Combining of Allocations

Allocations can only be combined at certain times and only if your spouse is independently eligible for PEEHIP.

I wish to ☐ transfer ☐ receive the state insurance allocation ☐ to ☐ from my spouse.

Spouse's Social Security Number: ____-____-____ | Effective Date of Combining Allocations: ____/____/____

Additional (Non-PEEHIP) Group Health Insurance Coverage Information

This section must be completed if the member elects the PEEHIP Supplemental Plan **or** if the member or dependent(s) have other group health, dental, or vision coverage currently in effect.

Name of Insurance Company	Policy Number
Name of Policy Holder	Relationship to Policy Holder

Policy Effective Date	Type of Coverage
____/____/____	☐ Single ☐ Family

Medicare Information

This section must be completed if you or your dependents are eligible for Medicare.

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:____/____/____ ☐ Part B-Effective:____/____/____ ☐ Part D*-Effective:____/____/____

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:____/____/____ ☐ Part B-Effective:____/____/____ ☐ Part D*-Effective:____/____/____

**If you are enrolled in Medicare Part D, you are not eligible for the PEEHIP prescription drug plan coverage.*

Retiree Other Employer Information

The following fields must be completed by PEEHIP members who retire after September 30, 2005.

Pursuant to Act 2004-649, if you retire after September 30, 2005, and become employed by another employer and the other employer provides at least 50% of the cost of single health insurance coverage, you are required to use the other employer's health benefit plan for primary coverage. You may enroll in the PEEHIP Supplemental Plan or the PEEHIP Optional Plans.

Are you employed? ☐ Yes ☐ No | If yes, please complete the employer information below.

Employer	Date of Employment	Last Day Employed
	____/____/____	____/____/____

Mailing Address	City	State	ZIP Code

Are you eligible for health insurance with your employer? ☐ Yes ☐ No

If yes, will your employer pay at least 50% of the cost of single health insurance coverage? ☐ Yes ☐ No

Name of Insurance Company	Policy Effective Date	Type of Coverage
	____/____/____	☐ Single ☐ Family

PEEHIP Subscriber Certification

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan's behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse's tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Employee Signature _____ Date Signed ____/____/____

Please mail the completed form to the address located on the front of this form.

PEEHIP FSA
(09/08)
2H

FLEXIBLE SPENDING ACCOUNT ENROLLMENT APPLICATION

ACTIVE MEMBERS ONLY

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

In lieu of completing and mailing this form, you can make your changes online using the Web site above.

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Name/Initial	Last Name
_____-_____-_____			

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone	
_____/_____/_____	_____-_____-_____	_____-_____-_____	

Healthcare Flexible Spending Account Information

I wish to enroll in the Health Care Flexible Spending Account. ☐Yes ☐No

Monthly Contribution Amount $ _____ × 12 months = $ _____ Annual Contribution Amount.

I understand that:

- PEEHIP will divide this amount by 12 (pay periods) and will reduce my pay by this amount during those pay periods during the plan year.
- Do not include health insurance premiums in your annual election amount.
- The maximum annual amount cannot exceed $5,000 and the minimum annual amount is $120.

Dependent Care Flexible Spending Account Information

I wish to enroll in the Dependent Care Flexible Spending Account. ☐Yes ☐No

Monthly Contribution Amount $ _____ × 12 months = $ _____ Annual Contribution Amount.

I understand that:

- PEEHIP will divide this amount by 12 (pay periods) and will reduce my pay by this amount during those pay periods during the plan year.
- Do not enroll in the Dependent Care Flexible Spending Account for reimbursement of out-of-pocket medical costs for dependents. You must use the Healthcare Flexible Spending Account instead.
- The maximum annual amount cannot exceed:
  - $5,000 if single or married filing a joint return, or
  - $2,500 if married filing a separate return.
- The minimum annual amount is $120.
- Remember to factor in the summer childcare costs.

PEEHIP Subscriber Certification

I understand that:

- I cannot change or revoke any of my elections on this compensation redirection agreement at any time during the plan year (Oct. 1 – Sep. 30) unless I have a qualifying change in status.
- During the Annual Open Enrollment Period, I will be given the opportunity to enroll in the plan for the upcoming plan year (Oct. 1 – Sep. 30). I must enroll each year during the Open Enrollment period since participation in the plan for subsequent years is not automatic, even if I want to contribute the same amount as the previous year.
- Amounts unused and unspent in the Healthcare Flexible Spending Account as of September 30 can be used to pay for out-of-pocket medical expenses incurred during the 2 ½ month grace period ending December 15.
- Expenses for both the Healthcare Flexible Spending Account and Dependent Care Flexible Spending Account can be submitted to Blue Cross by January 15 following the end of the plan year.

I hereby certify that I have completely read and fully understand the terms and conditions of the Flexible Spending Account and all information furnished is true and complete.

Employee Signature _____ Date Signed ____/____/____

PEEHIP FSA Change
(09/08)
2I

FLEXIBLE SPENDING ACCOUNT STATUS CHANGE

ACTIVE MEMBERS ONLY

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

In lieu of completing and mailing this form, you can make your changes online using the Web site above.

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Name/Initial	Last Name
_____-_____-_____			

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone
_____/_____/_____	_____-_____-_____	_____-_____-_____

Reason for Status Change

I certify that I have incurred the following change in status:

- ☐ Marriage
- ☐ Marriage of dependent
- ☐ Birth of a child
- ☐ Adoption of a child
- ☐ Legal custody of a child
- ☐ Divorce/annulment
- ☐ Death of spouse/dependent
- ☐ Dependent loss of coverage
- ☐ Significant change in medical benefits or premiums
- ☐ Termination of spouse/dependent employment
- ☐ Commencement of spouse/dependent employment
- ☐ Taking leave under the Family and Medical Leave Act
- ☐ Medicare/Medicaid entitlement
- ☐ Unpaid Leave of Absence
- ☐ Short plan year

Date qualifying event occurred ***(Required)*** _____/_____/_____

Note: *PEEHIP must be notified within 45 days of the occurrence of the qualifying event.*

Healthcare Flexible Spending Account Information

Healthcare Flexible Spending Account Change Request:

Note: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____ × 12 months = $ _____ Annual Amount

Maximum amount cannot exceed $5,000 and the minimum annual amount is $120.

☐ Stop Payroll Deductions

Dependent Care Flexible Spending Account Information

Dependent Care Flexible Spending Account Change Requested:

Note: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____ × 12 months = $ _____ Annual Amount

Maximum amount cannot exceed $5,000 if single or married filing a joint return, $2,500 if married filing separate returns. The minimum annual amount is $120.

☐ Stop Payroll Deductions

PEEHIP Subscriber Certification

I understand that Federal regulations prohibit me from changing the election I have made after the beginning of the plan year, except under special circumstances. I understand that the change in my benefit election must be necessary or appropriate as a result of the status change under the regulations issued by the Department of the Treasury. I hereby certify under penalties of perjury that the information furnished in this form is true and complete to the best of my knowledge.

Employee Signature _____ Date Signed _____/_____/_____

PEEHIP FPL & CHIP
(09/08)
2G

FEDERAL POVERTY LEVEL ASSISTANCE APPLICATION (FPL)
AND
CHILDREN'S HEALTH INSURANCE PROGRAM APPLICATION (CHIP)

I'm applying for:
- ☐ FPL
- ☐ CHIP
- ☐ FPL and CHIP

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

This form is to be used to apply for the Federal Poverty Level Premium Assistance and/or to apply/enroll in PEEHIP CHIP.

PEEHIP Subscriber Information - *Required*

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Name/Initial	Last Name
_____-_____-_____			

Mailing Address	City	State	ZIP Code

Home Phone	Work Phone	Date Received *(For internal use only)*
_____-_____-_____	_____-_____-_____	_____/_____/_____

Children's Health Insurance Plan Applicants Only

Note: *Social Security Number is required for all household members. Name must be entered as it appears on the Social Security card.*

Is any child covered under Medicaid? ☐ Yes ☐ No | If yes, which child(ren)?

Names of Household Members *Line A – PEEHIP Subscriber* *Line B – Subscriber's Spouse* *Lines C-F – Children under 19 years of age living in your home*	Social Security Number	Date of Birth	Age	Sex	Relationship to PEEHIP Subscriber
A.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	Self
B.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	Spouse
C.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	
D.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	
E.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	
F.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	

Requested Effective Date _____/_____/_____ ***(required)***

If you do not qualify for CHIP, do you wish to enroll children under the PEEHIP Hospital/Medical Plan? ☐ Yes ☐ No

Do any of these dependent children have other health insurance coverage? ☐ Yes ☐ No

If yes, which child(ren)? *(A copy of the insurance card is required.)*

Instructions

1. A **signed** copy of your prior year's Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099's and W-2's must be attached. If you were married and did not file a joint return, you must also file a copy of your spouse's prior year's Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099's and W-2's in order for this application to be processed.
2. You must reapply for this assistance every year during Open Enrollment.
3. Any Federal Poverty Level assistance application received and/or postmarked after the close of Open Enrollment (September 1) will be effective for the first day of the second month after the receipt and approval of the application.

PEEHIP Subscriber Certification - *Required*

I declare that the above information and the accompanying tax returns and supporting 1099's and W-2's are true, complete, and accurate. I understand that submitting false or misleading information on this application is a crime punishable under state and federal law. I also understand that if any statements or accompanying tax returns and supporting 1099's and W-2's are found to be incorrect, incomplete, false, or misleading, I will be required to repay all discounts plus interest. This certification authorizes the Alabama Department of Revenue (or corresponding agency of the state of member's residency) to release to PEEHIP all of the member's and his/her spouse's tax returns in the agency's records for the current and prior tax year.

Employee Signature _____ Date Signed _____/_____/_____

Spouse Signature _____ Date Signed _____/_____/_____

Please mail the completed form to the address located on the top of this form.
See reverse for FPL discounts and levels.

FEDERAL POVERTY LEVEL ASSISTANCE PROGRAM (FPL)

PEEHIP provides premium assistance to PEEHIP members with a combined family income of less than or equal to 200% of the Federal Poverty Level (FPL) as defined by Federal Law. To qualify for the FPL assistance, PEEHIP members must furnish acceptable proof of total income based on their most recently filed Federal Income Tax Return. Certification of Income Level will be effective for the plan year only, and re-certification will be required annually during Open Enrollment. The premium reduction does not automatically renew each year. The premium reduction will apply only to the hospital medical premium or HMO premium and only applies to active and retired members. The FPL premium discount is not available to members who are on a Leave of Absence, COBRA or surviving spouse contract.

Federal Poverty Level Premium Discount:

Over 200% of the FPL	member pays 100% of the member contribution	
equal to or less than 200% but more than 175% of the FPL	member contribution reduced 10%	Member pays 90%
equal to or less than 175% but more than 150% of the FPL	member contribution reduced 20%	Member pays 80%
equal to or less than 150% but more than 125% of the FPL	member contribution reduced 30%	Member pays 70%
equal to or less than 125% but more than 100% of the FPL	member contribution reduced 40%	Member pays 60%
equal to or less than 100% of the FPL	member contribution reduced 50%	Member pays 50%

2008 Federal Poverty Levels (FPL)

Family Size	100% of FPL	125% of FPL	150% of FPL	175% of FPL	200% of FPL
1 member	$10,400	$13,000	$15,600	$18,200	$20,800
2 members	$14,000	$17,500	$21,000	$24,500	$28,000
3 members	$17,600	$22,000	$26,400	$30,800	$35,200
4 members	$21,200	$26,500	$31,800	$37,100	$42,400
5 members	$24,800	$31,000	$37,200	$43,400	$49,600
6 members	$28,400	$35,500	$42,600	$49,700	$56,800
7 members	$32,000	$40,000	$48,000	$56,000	$64,000
8 members	$35,600	$44,500	$53,400	$62,300	$71,200
For each additional person, add	$3,600	$4,500	$5,400	$6,300	$7,200

Public Education Employees' Health Insurance Plan
P.O. Box 302150
Montgomery, Alabama 36130-2150